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CUMULATIVE POCKET SUPPLEMENT

IDAHO CODE

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Idaho Code Commission

R. DANIEL BOWEN
JEREMY P. PISCA ANDREW P. DOMAN
COMMISSIONERS

TITLE 41

Place this supplement in the pocket of the corresponding volume of the set

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PUBLISHER'S NOTE

Amendments to laws and new laws enacted since the publication of the bound volume down to and including the 2014 regular session are compiled in this supplement and will be found under their appropriate section numbers.

This publication contains annotations taken from decisions of the Idaho Supreme Court and the Court of Appeals and the appropriate federal courts. These cases will be printed in the following reports:

Idaho Reports
Pacific Reporter, 3rd Series
Federal Supplement, 2nd Series
Federal Reporter, 3rd Series
United States Supreme Court Reports, Lawyers' Edition, 2nd Series

Title and chapter analyses, in these supplements, carry only laws that have been amended or new laws. Old sections that have nothing but annotations are not included in the analyses.

Following is an explanation of the abbreviations of the Court Rules used throughout the Idaho Code.

Idaho R. Civ. P.	Idaho Rules of Civil Procedure
Idaho Evidence Rule	Idaho Rules of Evidence
Idaho R. Crim. P.	Idaho Criminal Rules
Idaho Misdemeanor Crim. Rule	Misdemeanor Criminal Rules
I.I.R.	Idaho Infraction Rules
I.J.R.	Idaho Juvenile Rules
I.C.A.R.	Idaho Court Administrative Rules
Idaho App. R.	Idaho Appellate Rules

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USER'S GUIDE

To assist the legal profession and the layperson in obtaining the maximum benefit from the Idaho Code, a User's Guide has been included in the first, bound volume of this set.

ADJOURNMENT DATES OF SESSIONS OF LEGISLATURE

Year	Adjournment Date
2011	April 7, 2011
2012	March 29, 2012
2013	April 4, 2013
2014	March 20, 2014

TITLE 41

INSURANCE

CHAPTER 1

SCOPE OF INSURANCE CODE — GENERAL PROVISIONS

41-102. "Insurance" defined.

JUDICIAL DECISIONS

Applicability.

A company was not an insurer where there was no evidence in the record that the company had guaranteed or assured payment of members' claims; thus, the conclusion that the company's membership contract was an insurance contract because the company assumed some risk of paying its members' claims was clearly erroneous. Altrua Healthshare, Inc. v. Deal, 154 Idaho 390, 299 P.3d 197 (2013).

41-113. Compliance required — Public interest.

JUDICIAL DECISIONS

Negligence Per Se.

Where insured failed to show that his claims were covered under his policy and the district court found that insured had not shown that the insurer engaged in any deceptive conduct or acted without good faith in handling or denying the insured's claims, the court properly dismissed the insured's negligence per se claim. Rizzo v. State Farm Ins. Co., — Idaho —, 305 P.3d 519 (2013).

41-121. Exemption of health care sharing ministries from the insurance code. — (1) A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of this title.

(2) As used in this section, "health care sharing ministry" means a faith-based nonprofit organization that is tax exempt under the Internal Revenue Code which:

(a) Limits its participants to those who are of a similar faith;

(b) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;

(c) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;

(d) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;

(e) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; and

(f) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

(3) It is hereby declared that participation in or operation of a health care sharing ministry does not constitute an unfair or deceptive act or practice in the conduct of trade or commerce prohibited by chapter 6, title 48, Idaho Code.

History.
I.C., § 41-121, as added by 2013, ch. 156, § 2, p. 369.

STATUTORY NOTES

Federal References.
The Internal Revenue Code, referred to in subsection (2), is codified as 26 U.S.C.S. § 1 et seq.

Compiler's Notes.
Section 1 of S.L. 2013, ch. 156 provided: "Short title. This act shall be known as the 'Health Care Sharing Ministries Freedom to Share Act.'"

Section 3 of S.L. 2013, ch. 156 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

CHAPTER 2

THE DEPARTMENT OF INSURANCE

SECTION.

41-211. Rules.

JUDICIAL DECISIONS

Limitation on Rules.
Plain text of § 41-1042 permits a bail bond company to contemporaneously write a bail bond and contract with a client to indemnify the company for the cost of apprehending a defendant who jumps bail. Idaho Admin. Code R. 18.01.04.016.02, which forbids such contracts, contravenes the statute and prejudices the company's substantial right to contract freely, contrary to § 67-5279. Two Jinn, Inc. v. Idaho Dep't of Ins., 154 Idaho 1, 293 P.3d 150 (2013).

41-212. Orders, notices. — (1) Orders and notices of the director shall be effective only when in writing signed by him or by his authority.

(2) Every such order shall state its effective date, and shall concisely state:

(a) Its intent or purpose.

(b) The grounds on which based.

(c) The provisions of this code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the director of the right to rely thereon.

(3) Except as may be provided in this code respecting particular procedures, an order or notice may be given by:

(a) Personal service upon the person to be ordered or notified;

(b) Mailing it, postage prepaid, by regular United States mail, or by certified mail, return receipt requested, addressed to the person at his residence or principal place of business as last of record in the department; or

(c) Where a party has appeared in a contested case or has not yet appeared but has consented or agreed in writing to service by facsimile transmission (FAX) or e-mail as an alternative to personal service or

service by mail, such orders or notices may be served by FAX or by e-mail in lieu of service by mail or personal service.

(4) Service of orders and notices is complete when a copy is personally served upon the person to be served, or when a copy properly addressed and postage prepaid is deposited in the United States mail or the statehouse mail, if the person is a state employee or state agency, or when there is an electronic verification that a FAX or an e-mail has been sent.

History.
1961, ch. 330, § 29, p. 645; am. 2012, ch. 157, § 1, p. 433.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 157, in subsection (3), divided the existing provisions into an introductory paragraph and present paragraphs (a) and (b), deleted "delivery to" at the end of the introductory paragraph, added "Personal service upon" in paragraph (a), substituted the present provisions in paragraph (b) for "mailing it, postage prepaid, addressed to him at his residence or principal place of business as last of record in the department. Notice so mailed shall be deemed to have been given when deposited in a letter depository of a United States post office", and added paragraph (c); and added subsection (4).

Compiler's Notes.
The abbreviation in parentheses so appeared in the law as enacted.

CHAPTER 3

AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

41-308. General eligibility for certificate of authority.

RESEARCH REFERENCES

Idaho Law Review. — Anatomy of a Mortgage Meltdown: The Story of the Subprime Crisis, the Role of Fraud, and the Efficacy of the Idaho SAFE Act, Comment. 48 Idaho L. Rev. 123 (2011).

CHAPTER 4

FEES AND TAXES

SECTION.

41-406. Deposit and report of fees, licenses and taxes. — (1) The director shall transmit all taxes, fines and penalties collected by him to the state treasurer as provided under section 59-1014, Idaho Code. The director shall file with the state controller a statement of each deposit thus made. All such funds received shall be deposited into the department of insurance suspense account.

Such funds shall be distributed as follows:

(a) The director may deposit up to twenty percent (20%) of the funds

received in the insurance refund account which is hereby created for the purpose of repaying overpayments of any taxes, fines, and penalties or other erroneous receipts. There is hereby appropriated out of the insurance refund account so much thereof as shall be necessary for the payment of refunds. Any unencumbered balance remaining in the insurance refund account on June 30 of each and every year in excess of forty thousand dollars ($40,000) shall be transferred to the general fund and the state controller is hereby authorized and directed on such dates to make such transfers unless the board of examiners, which is hereby authorized to do so, changes the date of transfer or sum to be transferred.

(b) That portion of the premium tax, payable to the public employee retirement fund as provided in section 59-1394, Idaho Code, shall be distributed to that fund.

(c) That portion of the premium tax necessary to cover administrative costs incurred by the department in placing insurance companies or any other insurance entities into receivership or under administrative supervision, and such costs cannot be satisfied from the assets of these companies or entities, shall be distributed to the insurance insolvency administrative fund which is hereby created. There is hereby appropriated out of the insurance insolvency administrative fund so much thereof as shall be necessary, but not to exceed two hundred thousand dollars ($200,000) in any one (1) fiscal year, for the payment of the department's administrative expenses incurred in carrying out such receiverships or supervision. A balance of one hundred thousand dollars ($100,000) shall be maintained in this fund on June 30 of each year.

(d) **[Null and void, effective October 1, 2015]** After all other deductions authorized in this section have been made, if the premium tax remaining exceeds forty-five million dollars ($45,000,000), one-fourth (1/4) of such excess is hereby appropriated and shall be paid to the Idaho high risk individual reinsurance pool established in chapter 55, title 41, Idaho Code, and one-fourth (1/4) of such excess above fifty-five million dollars ($55,000,000) is hereby appropriated and shall be paid to the Idaho health insurance access card fund, established in section 56-242, Idaho Code.

(e) The balance of the premium tax, fines and penalties shall be distributed to the general fund of the state of Idaho.

(f) All moneys received for fees, licenses and miscellaneous charges collected shall be distributed to the insurance administrative account.

(2) The director shall make and file with the state controller an itemized statement of the fees, licenses, taxes, fines and penalties collected by him during the preceding month.

History.

I.C., § 41-406, as added by 1984, ch. 23, § 3, p. 38; am. 1987, ch. 340, § 5, p. 720; am. 1993, ch. 118, § 1, p. 295; am. 1994, ch. 180, § 82, p. 420; am. 2000, ch. 64, § 1, p. 144; am. 2000, ch. 472, § 18, p. 1602; am. 2003, ch. 308, § 8, p. 844; am. 2012, ch. 158, § 1, p. 433; am. 2013, ch. 90, § 1, p. 221.

STATUTORY NOTES

Cross References.

Board of examiners, Idaho Const., Art. IV, § 18 and § 67-2001 et seq.

General fund, § 67-1205.

Amendments.

The 2012 amendment, by ch. 158, deleted "and shall deliver a certified copy of the statement to the state treasurer" from the end of subsection (2).

The 2013 amendment, by ch. 90, deleted "with eighty percent (80%) of such moneys to be appropriated to the CHIP Plan B subaccount and the children's access card program subaccount and twenty percent (20%) of such moneys, not to exceed one million two hundred thousand dollars ($1,200,000) per year, to be appropriated to the small business health insurance pilot program subaccount" from the ending of paragraph (1)(d).

Compiler's Notes.

Section 2 of S.L. 2013, ch. 90 provided: "The provisions of subsection (1)(d) of Section 1 of this act shall be null, void and of no force and effect on and after October 1, 2015."

CHAPTER 7

INVESTMENTS

41-706. Diversification of investments. — An insurer shall invest in or hold as assets categories of investments within applicable limits as follows only:

(1) One (1) person. An insurer shall not, except with the consent of the director, have at any one (1) time any combination of investments in or loans upon the security of the obligations, property, or securities of any one (1) person, institution, corporation, or municipal corporation, aggregating an amount exceeding ten percent (10%) of the insurer's assets. This restriction shall not apply as to investments or deposits fully insured by the federal deposit insurance corporation or to general obligations of the United States of America or of any state or include policy or annuity contract loans made under section 41-718, Idaho Code, or to assets subject to section 41-715 or 41-3803, Idaho Code, or to any one (1) domestic reciprocal insurer which exclusively insures members who are political subdivisions, as defined by section 6-902 2., Idaho Code, provided that all such investments comply with the public depository laws.

(2) Voting stock. An insurer shall not invest in or hold at any one (1) time more than ten percent (10%) of the outstanding voting stock of any corporation, except with the consent of the director given with respect to voting rights of preference stock during default of dividends. This provision does not apply as to stock of subsidiaries of the insurer or a companion company or companies under substantially the same management at the time of purchase, as referred to in section 41-715 or 41-3803, Idaho Code.

(3) Minimum capital. An insurer (other than title insurer) shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for

under the following sections of this chapter: section 41-707, Idaho Code, (public obligations), and section 41-721, Idaho Code, (real estate mortgages and contracts).

(4) Life insurance reserves. A life insurer shall also invest and keep invested its funds in an amount not less than the reserves under its life insurance policies and annuity contracts in force, as prescribed by section 41-612, Idaho Code, in cash and/or the securities or investments allowed under this chapter, other than in common stocks, insurance stocks and stocks of subsidiaries of the insurer.

(5) Other specific limits. Limits as to investments in the category of real estate shall be as provided in section 41-728, Idaho Code; and other specific limits shall apply as stated in the sections dealing with other respective kinds of investments.

History.

1961, ch. 330, § 143, p. 645; am. 1971, ch. 122, § 4, p. 408; am. 1974, ch. 91, § 1, p. 1187; am. 1978, ch. 89, § 1, p. 165; am. 1983, ch. 189, § 2, p. 510; am. 1993, ch. 194, § 7, p. 492; am. 1996, ch. 245, § 1, p. 775; am. 2013, ch. 266, § 3, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated references in subsections (1) and (2) in light of the 2013 revision at chapter 38, title 41, Idaho Code.

Compiler's Notes.

For more on the federal deposit insurance corporation, see *http://www.fdic.gov*.

41-714. Common stocks. — After satisfying the requirements of section 41-706(3) and (4), Idaho Code, (investment of capital and life reserves), an insurer may invest funds in an aggregate amount not in excess of fifteen percent (15%) of its assets in common shares of stock of any solvent institution existing under the laws of the United States or of any state, district or territory thereof, or of the government of Canada or any province thereof, that qualify as a sound investment, in addition to the shares of a substantially owned or wholly owned subsidiary corporation.

For the purpose of determining the investment limitation imposed by this section, the insurer shall value securities subject to the provisions of this section at the cost of the security or at the market value of the security, whichever is lower. However, investments in the shares of subsidiaries or companion insurance companies shall be governed by sections 41-715 and 41-3803, Idaho Code.

The limitations as to investment in common stocks as provided herein shall not apply to nor limit the right of investments in investment trust securities as provided for in section 41-716, Idaho Code.

History.

1961, ch. 330, § 151, p. 645; am. 1969, ch. 214, § 21, p. 625; am. 1971, ch. 122, § 5, p. 408; am. 1993, ch. 194, § 8, p. 492; am. 2003, ch. 219, § 2, p. 566; am. 2006, ch. 27, § 2, p. 86; am. 2013, ch. 266, § 4, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated a reference in the second paragraph in light of the 2013 revision of chapter 38, title 41, Idaho Code.

41-715. Insurance stocks. — (1) An insurer may invest in subsidiary and/or companion insurance companies not to exceed fifteen percent (15%) of assets. For the purpose of calculating this fifteen percent (15%) limitation, all investments made under this section and section 41-3803, Idaho Code, must be valued at market value of the security if actively traded, or at cost if not actively traded.

(2) The limitations on investments in insurance stocks set forth in this section shall not apply to stocks acquired under a plan for merger of the insurers which has been approved by the director or as to shares received as stock dividends upon shares already owned.

(3) Shares acquired and held under this section shall not, for the purposes of the limitations provided under section 41-714, Idaho Code, be included among other common stocks held by the insurer.

History.
1961, ch. 330, § 152, p. 645; am. 1969, ch. 214, § 22, p. 625; am. 1983, ch. 189, § 5, p. 510; am. 1993, ch. 194, § 9, p. 492; am. 2013, ch. 266, § 5, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated a reference in subsection (1) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

41-716. Investment trust securities. — (1) An insurer may invest in the securities of any open-end management type investment company or investment trust registered with the federal securities and exchange commission under the investment company act of 1940 as from time to time amended, if such investment company or trust has been organized for not less than three (3) years and has assets of not less than twenty-five million dollars ($25,000,000) as at the date of investment by the insurer. The aggregate amount invested under this section shall not exceed twenty-five percent (25%) of the insurer's assets with limitations of five percent (5%) of the insurer's assets in any one (1) fund and ten percent (10%) of the insurer's assets in any one (1) fund family.

(2) For the purpose of determining the investment limitation imposed by this section, the insurer shall value securities subject to the provisions of this section at the cost of the security or at the market value of the security, whichever is lower.

History.
1961, ch. 330, § 153, p. 645; am. 1983, ch. 189, § 6, p. 510; am. 1997, ch. 226, § 1, p. 664; am. 2003, ch. 219, § 3, p. 566; am. 2014, ch. 97, § 26, p. 265.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 97, made capitalization changes in subsection (1) and minor stylistic changes in subsection (2).

Federal References.
The Investment Company Act of 1940 is compiled as 15 U.S.C.S. § 80a-1 et seq.

41-731. Prohibited investments and investment underwriting. — (1) In addition to investments excluded under other provisions of this code, an insurer shall not directly or indirectly invest in or loan its funds upon the security of:

(a) Issued shares of its own capital stock, except for the purpose of mutualization under section 41-2854, Idaho Code, or in connection with a plan approved by the director for purchase of such shares by the insurer's officers, employees, or agents, or for other reasonable purposes under a plan filed with and approved by the director. No such stock shall, however, constitute an asset of the insurer in any determination of its financial condition.

(b) Except with the director's consent, any security issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, controlling stockholders, and the spouses and children of any of the foregoing individuals. Investments in subsidiaries under sections 41-706(2), 41-715 and 41-3803, Idaho Code, shall not be subject to this provision.

(c) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer, or the spouse or child of any of the foregoing individuals, except as to policy loans authorized under section 41-718, Idaho Code.

(d) Any investment or security which is found by the director to be designed to evade any prohibition of this chapter.

(2) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

History.
1961, ch. 330, § 168, p. 645; am. 1969, ch. 214, § 25, p. 625; am. 1971, ch. 122, § 7, p. 408; am. 1993, ch. 194, § 10, p. 492; am. 2013, ch. 266, § 6, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated a reference in paragraph (1)(b) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

41-733. Subsidiary investments. — An insurer may invest in subsidiaries in accordance with section 41-3803, Idaho Code.

History.
I.C., § 41-733, as added by 1969, ch. 214, § 26, p. 625; am. 1971, ch. 122, § 8, p. 408; am. 1974, ch. 91, § 5, p. 1187; am. 1983, ch. 189, § 7, p. 510; am. 1993, ch. 194, § 11, p. 492; am. 2013, ch. 266, § 7, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated the statutory reference in light of the 2013 revision of chapter 38, title 41, Idaho Code.

CHAPTER 9

INSURANCE ADMINISTRATORS

41-901. Definitions. — For the purposes of this chapter:

(1) "Administrator" or "third party administrator" or "TPA" means any person who directly or indirectly underwrites, collects charges or premiums from or adjusts or settles claims on residents of this state in connection with life, annuity or health insurance coverage offered or provided by an insurer, except any of the following:

(a) An employer, or a wholly owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one (1) or more subsidiaries or affiliated corporations of such employer.

(b) A union on behalf of its members.

(c) An insurance company that is either authorized to transact insurance in this state or acting as an insurer with respect to a policy lawfully issued and delivered by such company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business, or a hospital, medical, dental or optometric service corporation or a health care service organization, including their sales representatives, possessing a valid certificate of authority in this state when engaged in the performance of their duties.

(d) An insurance producer licensed to sell life, annuities or health coverage in this state whose activities are limited exclusively to the sale, solicitation and negotiation of insurance.

(e) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(f) A trust, its trustees, agents and employees acting pursuant to such trust established in conformity with 29 U.S.C. 186.

(g) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust or a custodian and the custodian's agents or employees acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code.

(h) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance producers or to limited lines producers or authorized insurers in connection with loan payments.

(i) A credit card issuing company that advances for and collects premiums

or charges from its credit cardholders who have authorized such collection.

(j) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life, annuity or health insurance coverage.

(k) A person licensed as a managing general agent in this state whose activities are limited exclusively to the scope of activities conveyed under such license.

(*l*) A person who is affiliated with an insurer and who acts solely as an administrator for the direct and assumed insurance business of an affiliated insurer. The insurer is responsible for the acts of the administrator and is responsible for providing all of the administrator's books and records to the insurance director upon a request from the insurance director. For purposes of this paragraph, "insurer" means a licensed insurance company, hospital or professional service corporation or a managed care organization.

(2) "Affiliate" or "affiliated" means an entity or person who directly or indirectly through one (1) or more intermediaries controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Control," including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in section 41-3809(11), Idaho Code, that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and an opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Director" means the director of the Idaho department of insurance.

(5) "GAAP" means United States "generally accepted accounting principles" consistently applied.

(6) "Home state" means the District of Columbia and any state or territory of the United States in which an administrator is incorporated or maintains its principal place of business. If neither the state in which the administrator is incorporated nor the state in which it maintains its principal place of business has adopted the provisions of this chapter, or a substantially similar law governing administrators, the administrator may declare another state in which it conducts business to be its "home state."

(7) "Insurer" means a person undertaking to provide life, annuity or health coverage or self-funded coverage who is subject to regulation under title 41, Idaho Code.

(8) "NAIC" means the "national association of insurance commissioners."

(9) "Nonresident administrator" means an administrator with a home state other than Idaho.

(10) "Underwrites" or "underwriting" means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer or self-funded plan, or the overall planning and coordinating of a benefits program.

(11) "Uniform application" means the current version of the NAIC uniform application for third party administrators.

History.

I.C., § 41-901, as added by 2010, ch. 31, § 2, p. 51; am. 2013, ch. 266, § 8, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the statutory reference in subsection (3) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

Section 501(a) and 401(f) of the internal revenue code, referred to in paragraph (1)(g), are compiled as 26 U.S.C.S. §§ 501(a) and 401(f).

Compiler's Notes.

For more on the national association of insurance commissioners, see *http://naic.org*.

41-911. Home state license. — (1) A person shall apply to be an administrator in its home state and shall receive a license from the regulatory authority of its home state prior to performing any function of an administrator in this state.

(2) A person applying to Idaho as the home state shall submit to the director an application in the form prescribed by the director that shall include or be accompanied by the following information and documents:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, certificate of existence from the Idaho secretary of state and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(c) NAIC biographical affidavits for the individuals who are directly or indirectly responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholders or members holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant and any other person who directly or indirectly exercises control or influence over the affairs of the applicant;

(d) Audited annual financial statements or reports for the two (2) most recent fiscal years that demonstrate that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal

years, the uniform application shall include financial statements or reports, certified by at least two (2) officers, owners or directors of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;

(ii) Amounts for each entity shall be stated separately; and

(iii) Explanations of consolidating and eliminating entries shall be included.

The applicant shall also include such other information as the director may require in order to review the current financial condition of the applicant;

(e) In lieu of submitting audited financial statements, and upon written application by an applicant and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

(i) Reports compiled or reviewed by a certified public accountant; or

(ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the applicant must also secure and maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars ($20,000). Administrators of self-funded plans in Idaho are subject to the mandatory surety bond requirement found in subsection (8) of this section, regardless of whether they file audited or unaudited financial reports;

(f) A statement describing the business plan, including information on staffing levels and activities, proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting;

(g) The license application fee as provided for by rule; and

(h) Such other pertinent information as may be required by the director.

(3) An administrator licensed or applying for licensure under the provisions of this section shall make available for inspection by the director, copies of all contracts with insurers or other persons utilizing the services of the administrator.

(4) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for

examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the director.

(5) The director may refuse to issue a license if the director determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the director determines that any of the grounds set forth in section 41-915, Idaho Code, exist with respect to the applicant.

(6) A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the director, for so long as the administrator continues in business in this state and remains in compliance with the provisions of this chapter and any applicable rules.

(7) An administrator licensed or applying for licensure under the provisions of this section shall immediately notify the director of any material change in its ownership, control or other fact or circumstance affecting its qualification for a license in this state.

(8) An administrator licensed or applying for a home state license that administers or will administer self-funded health plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, shall maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty. The bond shall be in the greater of the following amounts:

(a) One hundred thousand dollars ($100,000); or

(b) An amount equal to the greater of ten percent (10%) of the contributions collected by the administrator from self-funded plans subject to regulation under chapters 40 and 41, title 41, Idaho Code, or ten percent (10%) of the benefits paid by such self-funded plans administered during the preceding calendar year. If the administrator did not administer any self-funded plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, during the preceding calendar year, the bond shall be in an amount equal to ten percent (10%) of the contributions projected to be received by the administrator from such self-funded plans during the next calendar year.

History.

I.C., § 41-911, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 1, p. 430.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 156, in paragraph (2)(d), substituted "demonstrate" for "prove" in the first sentence and "certified by at least two (2) officers, owners or directors" for "certified by an officer" in the second sentence; added paragraph (2)(e), redesignating former paragraphs (2)(e), (f), and (g) as present paragraphs (2)(f), (g), and (h); substituted "applicant" for "administrator" three times in subsection (5); and, in the introductory paragraph in subsection (8), inserted "in a form prescribed by the director" and substituted "any insurer or self-funded plan" for "the insurer or insurers."

41-914. Annual report. — (1) Each administrator licensed under the provisions of this chapter shall file an annual report for the preceding calendar year with the director on or before July 1 of each year, or within such extension of time as the director for good cause may grant. The annual report shall include:

(a) An audited financial statement attested to by an independent certified public accountant. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;

(ii) Amounts for each entity shall be stated separately; and

(iii) Explanations of consolidating and eliminating entries shall be included.

(b) In lieu of submitting an audited financial statement, and upon written application by an administrator and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

(i) Reports compiled or reviewed by a certified public accountant; or

(ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the administrator must secure and maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars ($20,000).

(2) The annual report shall be in the form and contain such matters as the director prescribes and shall be verified by at least two (2) officers, owners or directors of the administrator.

(3) The annual report shall include the complete names and addresses of all insurers and for self-funded plans, all employers and trusts, with which the administrator had agreements during the preceding fiscal year. The report shall also include the number of Idaho residents covered by each of the plans.

History.

I.C., § 41-914, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 2, p. 430.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 156, in subsection (1), divided the existing provisions of the introductory paragraph into the present introductory paragraph and paragraph (a), added the (a) designation, substituting "attested to" for "performed" and redesignating the subordinate paragraphs, and added paragraph (b); in subsection (2), added the designation and inserted "annual" and "owners or directors"; and redesignated former subsection (2) as subsection (3), inserting "and for

self-funded plans, all employers and trusts" and adding the last sentence.

CHAPTER 10
PRODUCER LICENSING

41-1003. Definitions. — (1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(2) "Home state" means the District of Columbia and any state or territory of the United States or any province of Canada in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(3) "License" means a document issued by the director authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(4) "Limited lines insurance" is insurance which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 41-1008(1)(a) through (g), Idaho Code, and shall include, but not be limited to: credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance, transportation baggage insurance, transportation ticket policies covering personal accident insurance, pet insurance, portable electronics insurance or any other line of insurance that the director deems necessary to recognize for the purposes of complying with section 41-1009(5), Idaho Code.

(5) "Limited lines producer" means a producer authorized by the director to sell, solicit or negotiate limited lines insurance.

(6) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in the act either sells insurance or obtains insurance from insurers for purchasers.

(7) "Person" means an individual or a business entity.

(8) "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(9) "Resident" means a person whose home state is Idaho or any other particular state identified in conjunction with the use of the term.

(10) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(11) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company or companies.

(12) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance for or on behalf of an insurer.

(13) "Uniform application" means the current version of the national association of insurance commissioners (NAIC) uniform application for resident and nonresident producer licensing.

(14) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

History.
I.C., § 41-1003, as added by 2001, ch. 296, § 3, p. 1044; am. 2012, ch. 226, § 1, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, inserted "portable electronic insurance" near the end of subsection (4).

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1004. License required. — (1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed as a producer for that line of authority in accordance with this chapter.

(2) A person shall not, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho unless that person is:

(a) A licensed insurance producer offering advice concerning a class of insurance as to which the producer is licensed to transact business in this state;

(b) An attorney rendering services in the performance of the duties of an attorney;

(c) A certified public accountant rendering services in the performance of the duties of a certified public accountant, as authorized by law;

(d) An actuary rendering actuarial services if such actuary is a member of an organization determined by the director as establishing standards for the actuarial profession;

(e) A person providing services to producers or authorized insurers only;

(f) A person rendering services as an expert pursuant to the Idaho rules of evidence;

(g) An investment adviser, investment adviser representative or federally

covered investment adviser as defined in section 30-14-102, Idaho Code; or

(h) A person rendering such services pursuant to a license issued in accordance with sections 41-1081 through 41-1089 of this chapter.

History.
I.C., § 41-1004, as added by 2001, ch. 296, § 3, p. 1044; am. 2002, ch. 282, § 1, p. 825; am. 2004, ch. 45, § 6, p. 169; am. 2012, ch. 226, § 2, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, inserted paragraph (2)(h) and made stylistic changes.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1018. Appointments.

JUDICIAL DECISIONS

Agency.
Because insurance company did not grant express authority to an independent insurance agency to issue insured endorsements and certificates of liability, there could have been no implied authority, given that implied authority is dependent on the existence of express authority. Likewise, because there was no direct relationship or any alleged direct communication between the agency and the insurance company, no apparent authority could have existed. Nautilus Ins. Co. v. Pro-Set Erectors, Inc., 928 F. Supp. 2d 1208 (D. Idaho 2013).

41-1039. License required. — (1) No person shall hold himself out to be a bail agent or sell, solicit, negotiate, advise or consult regarding the terms of bail bond contracts in this state unless that person is licensed as a producer in the line of surety insurance. The director is vested with the exclusive authority to license bail agents and the authority to regulate the solicitation, negotiation and transaction of bail with retail consumers of bail bonds, provided however, that a court retains the authority to refuse to accept bail bonds from a surety or a bail agent pursuant to its inherent authority, pursuant to Idaho Code, or as provided by supreme court rules, guidelines or appellate decisions.

(2) A bail agent is authorized to execute and countersign undertakings of bail, including bail bonds, in connection with any judicial proceedings in each of the judicial districts of the state. Any sheriff or clerk of the district court shall accept bail bonds only from a bail agent, unless otherwise ordered by the court pursuant to subsection (1) of this section.

(3) In addition to the authority to revoke, suspend or refuse to issue a bail agent's license pursuant to section 41-1016, Idaho Code, the director shall suspend a license for a period not to exceed six (6) months, after mailing notice to the last known address of the bail agent but prior to a hearing, if such bail agent:

(a) Has been convicted or has entered a guilty plea to any felony or to a misdemeanor which evidences bad moral character, dishonesty, a lack of

integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public; or

(b) Intentionally and fraudulently makes a false statement to a court in connection with a bail transaction.

(4) In addition to the provisions of subsection (3) of this section, the director may also suspend a license for a period not to exceed six (6) months, after mailing notice to the last known address of the bail agent but prior to a hearing, for reasons set forth in the rules of the department.

History.
I.C., § 41-1039, as added by 2003, ch. 104, § 3, p. 328; am. 2010, ch. 86, § 3, p. 165; am. 2013, ch. 36, § 1, p. 77.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 36, deleted former subsection (3), which read: "A bail agent's license filed with the clerk of the district court is deemed proof that such bail agent is licensed pursuant to this chapter"; redesignated former subsections (4) and (5) as present subsections (3) and (4); and, in present subsection (4), substituted "subsection (3)" for "subsection (4)".

41-1042. Collections and charges permitted.

JUDICIAL DECISIONS

Bond Contracts.
Plain text of this section permits a bail bond company to contemporaneously write a bail bond and contract with a client to indemnify the company for the cost of apprehending a defendant who jumps bail. Idaho Admin. Code R. 18.01.04.016.02, which forbids such contracts, contravenes the statute and prejudices the company's substantial right to contract freely, contrary to § 67-5279. Two Jinn, Inc. v. Idaho Dep't of Ins., 154 Idaho 1, 293 P.3d 150 (2013).

41-1081. Requirements for sale of portable electronics insurance — Findings — Purpose. — (1) Sections 41-1081 through 41-1089, Idaho Code, set forth requirements for the sale of portable electronics insurance in this state.

(2) The legislature finds that portable electronics insurers and insurance producers who sell, solicit or negotiate the offer or sale of such insurance in this state shall be supervised and regulated by the department of insurance in a uniform and consistent manner.

History.
I.C., § 41-1081, as added by 2012, ch. 226, § 3, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1082. Definitions. — As used in sections 41-1081 through 41-1089, Idaho Code:

(1) "Customer" means a person who purchases portable electronics or services.

(2) "Enrolled Customer" means a customer who purchases coverage under a portable electronics insurance policy issued to a vendor of portable electronics, which vendor would be the insured under a master or group policy.

(3) "Location" means any physical location in the state of Idaho or any website, call center site or similar location directed to residents of the state of Idaho.

(4) "Portable electronics" means electronic devices that are portable in nature and includes accessories and any services related to the use of such device.

(5)(a) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics against any one (1) or more of the following causes of loss: loss of the portable electronic device, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss;

(b) "Portable electronics insurance" does not include:

(i) A service contract as defined in section 41-114A, Idaho Code;

(ii) A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(iii) A homeowner's, renter's, private passenger automobile, commercial multi-peril or similar insurance policy.

(6) "Portable electronics transaction" means:

(a) The sale or lease of portable electronics by a vendor to a customer; or

(b) The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(8) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

History.
I.C., § 41-1082, as added by 2012, ch. 226, § 4, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1083. Licensure of vendors. — (1) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(2) A limited lines license issued pursuant to the provisions of this section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage

in this state. Upon request by the director to the supervising entity, the registry shall be open to inspection and examination by the director during regular business hours of the supervising entity.

(4) Notwithstanding any other provision of law, a limited lines license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

History.
I.C., § 41-1083, as added by 2012, ch. 226, § 5, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1084. Requirements for sale of portable electronics insurance. — (1) At every location where portable electronics insurance is offered or sold to customers, brochures or other written materials must be provided by the vendor to a prospective customer which:

(a) Disclose that portable electronics insurance may duplicate coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of insurance coverage;

(b) State that the purchase by the customer of a portable electronics insurance policy is not required in order to purchase or lease portable electronics or related services;

(c) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity and contact information of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the insurance coverage; and

(v) Key terms and conditions of the insurance coverage such as whether portable electronics may be repaired or replaced with similar make and model, reconditioned or nonoriginal manufacturer parts or equipment;

(d) Set forth the process for filing a claim, including a description of how to return portable electronics and any deadlines applicable thereto, any fees that may apply and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium.

(2) The director may order a vendor to stop using any brochure or other written material that violates the requirements of this section or is otherwise found to be misleading or false.

(3) Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(4) Eligibility and underwriting standards for customers electing to

purchase portable electronics insurance coverage shall be established for each portable electronics insurance program by the insurer issuing a policy to a vendor.

History.
I.C., § 41-1084, as added by 2012, ch. 226, § 6, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1085. Authority of vendors of portable electronics. — (1) Notwithstanding any other provision of law, the employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under the provisions of this chapter provided that:

(a) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to the provisions of this section;

(b) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity who shall supervise the administration of the program, to include development of a training program for employees and authorized representatives of the vendors concerning the applicable requirements of this chapter prior to the transaction of any personal electronics insurance. The training required by the provisions of this section shall comply with the following:

(i) The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product being offered or sold that is conducted and overseen by employees of the supervising entity that are licensed pursuant to this chapter;

(iii) Each employee and authorized representative shall receive basic instruction concerning the portable electronics insurance offered to customers and the disclosures required pursuant to section 41-1084, Idaho Code; and

(c) No employee or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself out as a limited lines or other licensed insurance producer.

(2) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for portable electronics insurance coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included

with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included in the portable electronics or related services purchased. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in a nonsegregated account and is required to remit such amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Failure to do so is a violation of this section. Vendors may receive compensation for billing and collection services.

History.
I.C., § 41-1085, as added by 2012, ch. 226, § 7, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1086. Responsibility for actions of others. — For purposes of licensing and regulation under title 41, Idaho Code, a portable electronics limited lines licensee shall be responsible for the actions of the licensee's employees and authorized representatives acting on the licensee's behalf in relation to portable electronics insurance transactions and matters arising out of the same. Any violation of this chapter by the licensee's employees and authorized representatives acting on the licensee's behalf shall be considered a violation by the licensee.

History.
I.C., § 41-1086, as added by 2012, ch. 226, § 8, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1087. Suspension or revocation of license. — If a vendor of portable electronics or its employee or authorized representative violates any applicable provision of this chapter including, but not limited to, section 41-1016, Idaho Code, or applicable provisions of chapter 13, title 41, Idaho Code, or an applicable rule, the director may:

(1) Impose an administrative penalty pursuant to section 41-117, Idaho Code. However, penalties arising from the same or similar conduct shall not exceed fifty thousand dollars ($50,000) in the aggregate; and

(2) Impose other penalties that the director deems necessary and reasonable, including:

(a) Prohibiting such vendor from transacting portable electronics insurance pursuant to the provisions of this section at specific business locations where violations have occurred or from using specific employees or representatives in the transaction of portable electronics insurance; and

(b) Suspending, revoking or refusing to renew the license of such vendor.

History.
I.C., § 41-1087, as added by 2012, ch. 226, § 9, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1088. Termination of portable electronics insurance. — Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice.

(2) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure or other evidence indicating that a change in the terms and conditions has occurred and a summary of material changes. An enrolled customer shall be entitled to reject any change to the terms and conditions or cancel coverage, and the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice from the customer that he wishes to cancel coverage.

(3) Notwithstanding subsection (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(4) Notwithstanding subsection (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(a) For nonpayment of premium;

(b) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(c) If an enrolled customer exhausts the aggregate limit of liability under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty (30) calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer and specifies the date of such termination.

(5) Where a portable electronics insurance policy is terminated by a

policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination, and any unearned premium shall be returned to the policyholder within sixty (60) days of such termination.

(6) An enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and the person paying the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice of cancellation from the customer.

(7) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to the provisions of this section or is otherwise required by law, it shall be in writing and sent within the required notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means if agreed to by the customer pursuant to section 28-50-105, Idaho Code, and as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to each affected enrolled customer's last known mailing address on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to each affected enrolled customer's last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics at the time of purchase of the portable electronics insurance coverage. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics shall be deemed consent to receive notices and correspondence by electronic means at such address so long as notice of that consent is simultaneously provided to the customer. The insurer or vendor of portable electronics shall maintain proof that the notice or correspondence was sent.

(8) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

History.
I.C., § 41-1088, as added by 2012, ch. 226, § 10, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1089. Application for license and fees. — (1) A sworn application

for a limited lines license to sell, solicit or negotiate portable electronics insurance shall be completed and filed with the department of insurance on forms prescribed by the director to include such information as the director deems necessary.

(2) The application shall:

(a) Provide the name, residence address and other information required by the director for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter, which designation shall satisfy the requirements of section 41-1007(2)(b), Idaho Code. However, if the vendor derives more than fifty percent (50%) of its revenue from the sale of portable electronics insurance, the information noted in this subsection shall be provided for all officers, directors, and shareholders of record having beneficial ownership of ten percent (10%) or more of the vendor;

(b) Provide the location of the applicant's home office, both street address and mailing address, and phone number where such applicant may be reached during regular business hours; and

(c) Provide the syllabus for the training program that is developed by the supervising entity or the insurer that issued the portable electronics insurance policy to the vendor.

(3) Any vendor engaging in portable electronics insurance transactions on or before the effective date of sections 41-1081 through 41-1089, Idaho Code, must apply for licensure within ninety (90) days of the application being made available to the vendor by the director. Any applicant commencing operations after the effective date of sections 41-1081 through 41-1089, Idaho Code, must obtain a license prior to offering or selling portable electronics insurance.

(4) Notwithstanding any other provision of law, applicants for licensure pursuant to sections 41-1081 through 41-1089, Idaho Code, whose home state does not issue a producer license with a similar line of authority as the license authorized by such sections shall be issued a portable electronics limited lines license upon satisfying all applicable requirements of this chapter. However, any licensee whose home state does not authorize a limited lines license for portable electronics insurance in its home state after July 1, 2014, or such later date as may be determined by the director, shall obtain a property and casualty license under title 41, Idaho Code, or its license shall terminate in Idaho. For the purposes of this subsection, "home state" means the District of Columbia and any state or territory of the United States except Idaho, or any province of Canada, in which an applicant maintains such person's principal place of residence or principal place of business.

(5) Initial licenses issued pursuant to sections 41-1081 through 41-1089, Idaho Code, shall be valid for a period of twenty-four (24) months and expire thereafter unless renewed by the director upon completion of forms required by the director and payment of fees consistent with the provisions of this chapter.

(6) Each vendor of portable electronics licensed pursuant to this chapter shall pay to the director a fee of one thousand dollars ($1,000) for an initial

portable electronics limited lines license and five hundred dollars ($500) for each renewal thereof. However, for a vendor engaged in portable electronics transactions at ten (10) or fewer locations in the state of Idaho, the fee shall not exceed one hundred dollars ($100) for an initial license and for each renewal thereof.

History.
I.C., § 41-1089, as added by 2012, ch. 226, § 11, p. 619.

STATUTORY NOTES

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

CHAPTER 11

ADJUSTERS

41-1102. "Adjuster" defined. — (1) An "adjuster" is a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of such an independent contractor, or for fee or commission, investigates and negotiates settlement of claims arising under insurance contracts.

(2) None of the following is an "adjuster" for the purposes of this chapter:

(a) A licensed attorney at law who is qualified to practice law in this state.

(b) The salaried employee of an authorized insurer, or group of such insurers under common control or ownership, or of a managing general agent, who adjusts losses for such insurer or insurers or for the authorized insurers represented by the general agent.

(c) The licensed agent of an authorized insurer who, at the insurer's request, from time to time adjusts or assists in adjustment of losses arising under policies issued by such insurer.

(d) An individual who collects claim information from, or furnishes claim information to, claimants or those who are insured and who conducts data entry, including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed adjuster or licensed agent. A licensed agent who acts as a supervisor or adjusts claims pursuant to the provisions of this paragraph is not required to also be licensed as an adjuster. For purposes of this section, "automated claims adjudication system" means a pre-programmed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims that:

(i) May only be utilized by a licensed adjuster, licensed agent or

supervised individuals operating pursuant to the provisions of this paragraph;

(ii) Must comply with all claims payment requirements of the insurance code; and

(iii) Must be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity pursuant to the provisions of this chapter.

History.
1961, ch. 330, § 238, p. 645; am. 2012, ch. 226, § 12, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, added paragraph (2)(d).

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1103. License required. — No person shall in this state be, act as, or advertise or hold himself out to be, an adjuster unless then licensed as an adjuster under this chapter. No resident of Canada may be licensed as a resident adjuster or may designate Idaho as his home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable provisions of this chapter. No resident of Canada may be licensed as a nonresident adjuster unless such person has obtained a resident or home state adjuster license in another state.

History.
1961, ch. 330, § 239, p. 645; am. 2012, ch. 226, § 13, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, added the second and third sentences.

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

41-1104. Qualifications for adjuster's license. — (1) Except as provided in subsection (2) of this section, the director shall not issue, continue, or permit to exist any license as an adjuster as to any person not qualified therefor as follows:

(a) Must be a natural person not less than twenty-one (21) years of age.

(b) Must be trustworthy, and be of good character and reputation as to morals, integrity, and financial responsibility, and must not have been convicted of a felony or of any crime involving moral turpitude.

(c) Must be a salaried employee of a licensed adjuster, or must have had experience or special education or training as to the investigation and settlement of loss of claims under insurance contracts of sufficient

duration and extent reasonably to satisfy the director as to his competence to fulfill the responsibilities of an adjuster.

(d) If required by the director, must pass a written examination to test his knowledge of the duties and responsibilities of an adjuster and of matters involved in transactions under an adjuster's license. The examination shall be subject to the same applicable provisions as apply pursuant to title 41, Idaho Code, to examinations for license as insurance agent.

(2) A firm or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers in this state is separately licensed, or is named in the firm or corporation license, and is qualified as for an individual license as adjuster under subsection (1) of this section. An additional full license fee shall be paid as to each individual in excess of one (1) so named in the firm or corporation license to exercise its powers.

History.
1961, ch. 330, § 240, p. 645; am. 1969, ch. 214, § 38, p. 625; am. 2012, ch. 226, § 14, p. 619.

STATUTORY NOTES

Amendments.
The 2012 amendment, by ch. 226, substituted "pursuant to title 41, Idaho Code" for "under this code" in paragraph (1)(d) and made stylistic changes.

Compiler's Notes.
Section 15 of S.L. 2012, ch. 226 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

Effective Dates.
Section 16 of S.L. 2012, ch. 206 provided that the act should take effect on and after July 1, 2013.

CHAPTER 12

UNAUTHORIZED INSURERS AND SURPLUS LINES

41-1212. Exemptions from surplus line law. — (1) The provisions of this surplus line law controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or, except as to subsection (2) below, to the following insurances when so placed by licensed agents or surplus line brokers of this state:

(a) Ocean marine and foreign trade insurances.

(b) Insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside this state.

(c) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations.

(d) Insurance of aircraft owned or operated by manufacturers of aircraft, or of aircraft operated in commercial scheduled interstate flight, or cargo

of such aircraft, or against liability, other than worker's compensation and employer's liability, arising out of the ownership, maintenance or use of such aircraft.

(2) Brokers so placing any such insurance with an unauthorized insurer shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this law. The record shall be preserved for not less than five (5) years from the effective date of the insurance and shall be kept available in this state and open to the examination of the director. The broker shall furnish to the director at his request and on forms as designated and furnished by him a report of all such coverages so placed in a designated calendar year.

(3) The following sections apply only when the insured's home state is Idaho:

(a) Section 41-1214, Idaho Code (conditions for export);

(b) Section 41-1215, Idaho Code (broker's affidavit);

(c) Section 41-1216, Idaho Code (open lines for export);

(d) Section 41-1217, Idaho Code (eligible surplus lines insurers);

(e) Section 41-1218, Idaho Code (eligible surplus line insurers — penalty for violation);

(f) Section 41-1219, Idaho Code (evidence of the insurance — changes — penalty);

(g) Section 41-1220, Idaho Code (endorsement of contract);

(h) Section 41-1227, Idaho Code (records of broker);

(i) Section 41-1228, Idaho Code (annual report of broker);

(j) Section 41-1229, Idaho Code (tax on surplus lines);

(k) Section 41-1233, Idaho Code (report and tax of independently procured coverages);

(*l*) Section 41-1234, Idaho Code (records of insureds).

History.
1961, ch. 330, § 256, p. 645; am. 1972, ch. 369, § 8, p. 1072; am. 2011, ch. 183, § 1, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, substituted "worker's compensation" for "workmen's compensation" in paragraph (1)(d) and added subsection (3).

41-1213. Definitions. — As used in this chapter and any applicable rules, the following definitions shall apply:

(1) "Affiliated" means, with respect to an insured, any entity that controls, is controlled by or is under common control with the insured.

(2) "Affiliated group" means any group of entities that are all affiliated.

(3) "Broker" means a surplus line broker duly licensed as such under this chapter, including resident surplus line brokers and nonresident surplus line brokers.

(4) "Control" means:

(a) An entity directly or indirectly, or acting through one (1) or more other persons, owns or controls another entity or has the power to vote

twenty-five percent (25%) or more of any class of voting securities of another entity; or

(b) An entity controls in any manner the election of a majority of the directors or trustees of another entity.

(5)(a) "Exempt commercial purchaser" means any person purchasing commercial insurance who, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager to negotiate insurance coverage.

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding twelve (12) months.

(iii) The person meets at least one (1) of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

3. The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate.

4. The person is a nonprofit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

5. The person is a municipality with a population in excess of fifty thousand (50,000) persons.

(b) The amounts provided in subparagraph (iii)1., 2. and 4. of paragraph (a) of this subsection must be adjusted to reflect the percentage change for the five (5) year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

(c) For the purposes of this subsection, "commercial insurance" means property and casualty insurance pertaining to a business, profession, occupation, nonprofit organization or public entity.

(6) "Export" means to place in an unauthorized insurer under this surplus line law insurance covering a subject of insurance resident, located, or to be performed in Idaho.

(7)(a) "Home state" means:

(i) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(ii) If one hundred percent (100%) of the insured risk is located out of state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, then "home state"

means the home state, as determined pursuant to the provisions of paragraph (a) of this subsection, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(c) For the purposes of this subsection, "principal place of business" means the state where the insured maintains its headquarters and where the insured's high level officers direct, control and coordinate the business activities of the insured.

(8) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(a) The person is an employee of, or a third party consultant retained by, the commercial policyholder;

(b) The person provides skilled services in loss prevention, loss reduction or risk and insurance coverage analysis, and purchase of insurance; and

(c) The person:

(i) Has at least ten (10) years of experience in risk financing, claim administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; or

(ii) Has a graduate degree from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competence in risk management; or

(iii) Has at least seven (7) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance and has one (1) of the designations specified in subparagraph (iv)1. through 5. of this paragraph; or

(iv) Has a bachelor's degree or higher education from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competency in risk management; and either has three (3) years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis or purchasing commercial lines of insurance, or has one (1) of the following designations:

1. A designation as a chartered property and casualty underwriter (CPCU) issued by the American institute for CPCU and insurance institute of America;

2. A designation as an associate in risk management (ARM) issued by the American institute for CPCU and insurance institute of America;

3. A designation as a certified risk manager (CRM) issued by the national alliance for insurance education and research;

4. A designation as a RIMS fellow (RF) issued by the global risk management institute; or

5. Any other designation, certification or license determined by a

state insurance director or other state insurance regulatory official or entity to demonstrate minimum competency in risk management.

History.
1961, ch. 330, § 257, p. 645; am. 2002, ch. 91, § 2, p. 227; am. 2011, ch. 183, § 2, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added the introductory language; added subsections (1) and (2); redesignated former subsection (1) as subsection (3), and therein deleted "as used in this chapter" following "'Broker'"; added subsection (4); redesignated former subsection (2) as subsection (6), and therein substituted "'Export'" for "To 'export'"; and added subsections (7) and (8).

41-1214. Conditions for export. — If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter designated "surplus lines," may be procured from unauthorized insurers, subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker who is a member of a surplus line association approved by the director.

(2) The full amount or kind of insurance required must not be procurable from insurers who are authorized to do business in this state. The amount of insurance exported shall be only the excess over the amount procurable from authorized insurers unless the excess is not available without support of other coverages, provided that a diligent search is made among the insurers authorized to transact and actually writing that particular kind and class of insurance in this state.

(3) The insurance must not be so exported for the purpose of securing advantages either as to:

(a) A lower premium rate than would be accepted by an authorized insurer; or

(b) Terms of the insurance contract.

(4) A surplus line broker seeking to procure from or place insurance with an unauthorized insurer for an exempt commercial purchaser is not required to satisfy the diligent search requirement set forth in subsection (2) of this section when:

(a) The surplus line broker or referring insurance producer procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(b) The exempt commercial purchaser has subsequently requested in writing the surplus line broker or referring insurance producer to procure or place such insurance from an unauthorized insurer.

(5) Records of the surplus line broker's satisfaction of the requirements of subsection (4) of this section shall be maintained in compliance with the provisions of section 41-1227, Idaho Code.

(6) A surplus line broker may not knowingly place surplus line insurance

with insurers that are financially unsound. The surplus line broker may only so insure with the following:

(a) Any foreign insurer that is authorized to write the kind of insurance in its domiciliary jurisdiction and has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals the greater of the following: (i) the minimum capital and surplus requirements under the laws of this state; or (ii) fifteen million dollars ($15,000,000); or

(b) Any alien insurer that is listed on the quarterly listing of alien insurers maintained by the international insurers department of the national association of insurance commissioners.

(7) The requirements in paragraph (a) of subsection (6) of this section may be satisfied by an insurer that possesses less than the minimum capital and surplus upon an affirmative finding of acceptability by the director. Such finding shall be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. The director is prohibited from making an affirmative finding of acceptability when the foreign insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

(8) The director may promulgate rules to prescribe the terms under which the financial requirements provided in this section may be waived in circumstances where insurance cannot be otherwise procured on risks located in this state.

(9) For any violation of the provisions of this section, a surplus line broker may be subject to a fine of not less than one hundred dollars ($100) and not more than five thousand dollars ($5,000), or the surplus line broker's license may be revoked, suspended or nonrenewed, or both such fine and license revocation, suspension or nonrenewal.

History.
1961, ch. 330, § 258, p. 645; am. 1993, ch. 22, § 2, p. 79; am. 2011, ch. 183, § 3, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added subsections (4) through (9).

41-1223. Licensing of surplus line brokers. — (1) Any individual while licensed as a producer licensed for property or casualty insurance who has had at least two (2) years' experience as a producer for the lines of insurance for which he is seeking to be licensed as a surplus line broker, and who is deemed by the director to be competent and trustworthy with respect to the handling of surplus lines, may be licensed as a surplus line broker.

(2) Application for the license shall be made to the director on forms as designated and furnished by the director.

(3) The license and continuation fee shall be as set forth by rule pursuant to section 41-401, Idaho Code.

(4) The license and licensee shall be subject to the applicable provisions of chapter 10, title 41, Idaho Code (producer licensing).

(5) When a national insurance producer database of the national association of insurance commissioners, or other equivalent uniform national database, for the licensure of surplus line brokers is created, the director may participate in such database.

History.
1961, ch. 330, § 267, p. 645; am. 1972, ch. 164, § 3, p. 376; 1976, ch. 118, § 3, p. 456; am. 2001, ch. 296, § 5, p. 1044; am. 2002, ch. 91, § 7, p. 227; am. 2011, ch. 183, § 4, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, added subsection (5).

41-1229. Tax on surplus lines. — (1) On or before the first day of March of each year each broker shall remit to the director a tax on the premiums, exclusive of sums collected to cover federal and state taxes and examination fees, on surplus line insurance subject to tax transacted by him with unauthorized insurers during the preceding calendar year as shown by his annual statement filed with the director, and at the rate of one and five-tenths percent (1.5%). Such tax shall be in lieu of all other taxes upon such insurers with respect to the business so reported.

(2) For property and casualty insurance other than worker's compensation insurance, if Idaho is the insured's home state, then the tax so payable shall be computed upon the entire premium under subsection (1) of this section, without regard to whether the policy covers risks or exposures that are located in Idaho. For all other lines of insurance, if a surplus line policy covers risks or exposures only partially in Idaho, the tax so payable shall be computed upon the proportion of the premium that is properly allocable to the risks or exposures located in Idaho.

History.
1961, ch. 330, § 273, p. 645; am. 1988, ch. 186, § 1, p. 325; am. 1988, ch. 366, § 4, p. 1077; am. 1994, ch. 383, § 3, p. 1229; am. 2004, ch. 387, § 1, p. 1163; am. 2011, ch. 183, § 5, p. 517.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 183, in subsection (1), substituted "and at the rate of one and five-tenths percent (1.5%)" for "and at the following rates" and deleted paragraphs (1)(a) and (1)(b), which concerned calendar years 2004 through 2007; and rewrote subsection (2), which formerly read: "If a surplus line policy covers risks or exposure only partially in this state, the tax so payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this state."

Effective Dates.
Section 6 of S.L. 2011, ch. 183 provided that the amendment of § 41-1229 should take effect on and after July 21, 2011.

CHAPTER 13

TRADE PRACTICES AND FRAUDS

SECTION.

41-1314. Rebates — Illegal inducements. — (1) Except as otherwise expressly provided by law, no person shall knowingly make, permit to be made, or offer to make any contract of insurance, or of annuity, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity or in connection therewith, any rebate of premiums payable on the contract, or of any producer's commission related thereto, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or directly or indirectly give, or sell, or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith, and whether or not specified or to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds, or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other person, or any dividends or profits accrued or to accrue thereon; or offer, promise or give anything of value whatsoever not specified in the contract. Nor shall any insured, annuitant, or policyholder or employee thereof, or prospective insured, annuitant or policyholder, or employee thereof, knowingly accept or receive, directly or indirectly, any such prohibited contract, agreement, rebate, advantage, employment, or other inducement.

(2) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed producers, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, the usual and ordinary dividends, savings, or unabsorbed premium deposits.

(3) Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes, goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars ($200) in a calendar year.

(4) Extension of credit for the payment of premium beyond the customary premium payment period without charging and collecting interest at a reasonable rate per annum on the amount of credit so extended and for the duration of such credit is prohibited under this section.

History.

1961, ch. 330, § 292, p. 645; am. 1969, ch. 214, § 46, p. 625; am. 2006, ch. 212, § 1, p. 643; am. 2011, ch. 259, § 1, p. 704.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 259, in subsection (1), substituted "producer's commission" for "agent's, solicitor's, or broker's commission"; in subsection (2), substituted "producers" for "agents, solicitors, or brokers"; and, in subsection (3), inserted "disability insurer," "disability insurance," and "disability" and substituted "aggregate value not to exceed two hundred dollars ($200) in a calendar year" for "aggregate value of fifty dollars ($50.00) or less."

41-1329. Unfair claim settlement practices.

JUDICIAL DECISIONS

Action in Tort by Insured.

In a suit stemming from an insurer's bad faith breach of contract, the trial court did not err in instructing the jury on this chapter, because such instruction did not, as the insurer argued, change the chapter from potential evidence of the industry standard to the law governing bad faith claims. Nowhere in its jury instruction did the court imply that the statute created a private right of action. Weinstein v. Prudential Prop. & Cas. Ins. Co., 149 Idaho 299, 233 P.3d 1221 (2010).

41-1336. Requirements for compliance.

JUDICIAL DECISIONS

Bankruptcy.

Debtors were allowed to claim an exemption with respect to an annuity, pursuant to paragraph (1)(b), where, although the funds used to purchase the annuity were derived from nonexempt sources, debtors acted in good faith in trying to settle claims against them and lacked fraudulent intent. In re Hall, 464 B.R. 896 (Bankr. D. Idaho 2012).

RESEARCH REFERENCES

A.L.R. — Purchase of annuity by debtor as fraud on creditors. 74 A.L.R.6th 549.

CHAPTER 16

WORKER'S COMPENSATION RATES

SECTION.

41-1618. Applicability of chapter as to certain powers of state insurance manager, and to certain public employment. [Repealed.]

Repealed by S.L. 2014, ch. 95, § 2, effective July 1, 2014.

History.

1961, ch. 330, § 379, p. 645.

CHAPTER 17

BUSINESS TRANSACTED WITH BROKER CONTROLLED INSURER

SECTION.

41-1702. Definitions. — As used in this chapter:

(1) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners (NAIC).

(2) "Broker" means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

(3) "Control" or "controlled" has the meaning ascribed in section 41-3802(2), Idaho Code.

(4) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a broker.

(5) "Controlling broker" means a broker who, directly or indirectly, controls an insurer.

(6) "Licensed insurer" or "insurer" means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following inter alia are not licensed insurers for the purposes of this chapter:

(a) All risk retention groups as defined in the superfund amendments reauthorization act of 1986, P.L. 99-499, 100 Stat. 1613 (1986) and the risk retention act 15 U.S.C. section 3901 et seq. (1982 and supp. 1986) and chapter 48, title 41, Idaho Code;

(b) All residual market pools and joint underwriting authorities or associations; and

(c) All captive insurers. For purposes of this chapter, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates.

History.
I.C., § 41-1702, as added by 1993, ch. 194, § 12, p. 492; am. 2013, ch. 266, § 9, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the statutory reference in subsection (3) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

CHAPTER 18

THE INSURANCE CONTRACT

41-1811. Representations in applications.

RESEARCH REFERENCES

A.L.R. — Rescission of directors' and officers' liability insurance policy. 29 A.L.R.6th 189.

41-1823. Binders. — (1) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such supplemental information and applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(2) No binder shall be valid beyond the issuance of the policy, or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given.

(3) This section shall not apply to life or disability insurances.

History.

1961, ch. 330, § 415, p. 645; am. 2012, ch. 314, § 2, p. 863.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 314, inserted "supplemental information and" in subsection (1); substituted "or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given" for "with respect to which it was given or beyond ninety (90) days from its effective date, whichever period is the shorter"; deleted former subsection (3), which read, "If the policy has not been issued a binder may be extended or renewed beyond such ninety (90) days with the written approval of the director, or in accordance with such rules and regulations relative thereto as the director may promulgate."; and renumbered former subsection (4) as present subsection (3).

Compiler's Notes.

Section 3 of S.L. 2012, ch. 314 provided "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declara-

tion shall not affect the validity of the remaining portions of this act."

41-1836. Exemption of proceeds — Annuity contracts — Assignability of rights. — (1) The benefits, rights, privileges and options which under any annuity contract heretofore or hereafter issued are due or prospectively due the annuitant, shall not be subject to execution nor shall the annuitant be compelled to exercise any such rights, powers, or options, nor shall creditors be allowed to interfere with or terminate the contract, except:

(a) As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity contract, the annuitant and the payments sought to be avoided on the ground of fraud.

(b) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which he is an annuitant, shall not at any time exceed one thousand two hundred fifty dollars ($1,250) per month for the length of time represented by such installments, and that such periodic payments in excess of one thousand two hundred fifty dollars ($1,250) per month shall be subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to any annuitant under all annuity contracts under which he is an annuitant, shall at any time exceed payment at the rate of one thousand two hundred fifty dollars ($1,250) per month, then the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(d) As to any deferred annuity contract having a cash surrender provision and from which no periodic payments are being made, the cash surrender value of the deferred annuity contract, not to exceed premiums paid into the deferred annuity contract within six (6) months prior to the filing of a bankruptcy petition, as defined in 11 U.S.C. section 101, or the date of attachment or levy on execution, as defined in section 11-201, Idaho Code, whichever is applicable.

(2) If the contract so provides, the benefits, rights, privileges or options accruing under such contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant, shall apply with respect to such beneficiary or assignee.

(3) An annuity contract within the meaning of this section shall be any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not such sums are payable to one (1) or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

(4) This section shall not be affected by the terms of section 15-6-107, Idaho Code.

History.

1961, ch. 330, § 428, p. 645; am. 2001, ch. 285, § 1, p. 1020; am. 2003, ch. 248, § 4, p. 639; am. 2013, ch. 246, § 1, p. 596.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 246, added paragraph (1)(d).

JUDICIAL DECISIONS

Exemption.

Under this section, annuity benefits that are due or prospectively due are exempt from the reach of the annuitant's creditors (as well as a bankruptcy trustee), but the exemption is limited to $1,250 per month for any benefits presently due and payable to any annuitant periodically or at stated times. An annuitant may seek to protect more $1,250 per month in benefit payments, but only upon a showing of need. The presumption is that annuity benefit payments to an annuitant in excess of the statutory cap are not exempt and are vulnerable to the claims of the annuitant's creditors. In re Wiley, 469 B.R. 326 (Bankr. D. Idaho 2012).

For the exemption of paragraph (1)(b) to apply in a bankruptcy proceeding, some sort of annuity benefit payment election must have been made by the debtor as of the date the bankruptcy petition is filed. Were this not the case, the mathematical calculation required by this section would be impossible. In re Wiley, 469 B.R. 326 (Bankr. D. Idaho 2012).

Because debtors did not show that the wife was a dependent of her former spouse, they could not exempt annuity payments under § 11-604(1)(c). However, the annuity payments were exempt under this section, but debtors were held to the statutory cap of $1,250 per month because their income was likely to exceed their expenses. In re Baldwin, 2012 Bankr. LEXIS 5376 (Bankr. D. Idaho Nov. 13, 2012).

Before filing for bankruptcy, debtors purchased annuity contracts which contained options for payment of the annuity in different ways, including a lump sum payment; at the time the case was heard, no option had been exercised. The contracts were exempt annuities for bankruptcy purposes, even though exercise of one or more of the options might diminish or remove the exemption, and the bankruptcy court could not force a debtor to exercise an option. Aden v. Gugino (In re Aden), 484 B.R. 379 (D. Idaho 2012).

Debtors' transfer of funds to purchase annunity immediately prior to their bankrutpcy filing constituted a transfer with intent to defraud creditors, warranting upholding the trustee's objection to the debtors' claimed exemption for the annuity. In re Preuit, 2013 Bankr. LEXIS 2331 (Bankr. D. Idaho June 7, 2013).

41-1839. Allowance of attorney's fees in suits against or in arbitration with insurers. — (1) Any insurer issuing any policy, certificate or contract of insurance, surety, guaranty or indemnity of any kind or nature whatsoever that fails to pay a person entitled thereto within thirty (30) days after proof of loss has been furnished as provided in such policy, certificate or contract, or to pay to the person entitled thereto within sixty (60) days if the proof of loss pertains to uninsured motorist or underinsured motorist coverage benefits, the amount that person is justly due under such policy, certificate or contract shall in any action thereafter commenced against the

insurer in any court in this state, or in any arbitration for recovery under the terms of the policy, certificate or contract, pay such further amount as the court shall adjudge reasonable as attorney's fees in such action or arbitration.

(2) In any such action or arbitration, if it is alleged that before the commencement thereof, a tender of the full amount justly due was made to the person entitled thereto, and such amount is thereupon deposited in the court, and if the allegation is found to be true, or if it is determined in such action or arbitration that no amount is justly due, then no such attorney's fees may be recovered.

(3) This section shall not apply as to actions under the worker's compensation law, title 72, Idaho Code. This section shall not apply to actions or arbitrations against surety insurers by creditors of or claimants against a principal and arising out of a surety or guaranty contract issued by the insurer as to such principal, unless such creditors or claimants shall have notified the surety of their claim, in writing, at least sixty (60) days prior to such action or arbitration against the surety. The surety shall be authorized to determine what portion or amount of such claim is justly due the creditor or claimant and payment or tender of the amount so determined by the surety shall not be deemed a volunteer payment and shall not prejudice any right of the surety to indemnification and/or subrogation so long as such determination and payment by the surety be made in good faith. Nor shall this section apply to actions or arbitrations against fidelity insurers by claimants against a principal and arising out of a fidelity contract or policy issued by the insurer as to such principal unless the liability of the principal has been acknowledged by him in writing or otherwise established by judgment of a court of competent jurisdiction.

(4) Notwithstanding any other provision of statute to the contrary, this section and section 12-123, Idaho Code, shall provide the exclusive remedy for the award of statutory attorney's fees in all actions or arbitrations between insureds and insurers involving disputes arising under policies of insurance. Provided, attorney's fees may be awarded by the court when it finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation. Section 12-120, Idaho Code, shall not apply to any actions or arbitrations between insureds and insurers involving disputes arising under any policy of insurance.

History.

1961, ch. 330, § 431, p. 645; am. 1965, ch. 105, § 1, p. 191; am. 1996, ch. 384, § 1, p. 1307; am. 1996, ch. 385, § 1, p. 1308; am. 2010, ch. 251, § 1, p. 641; am. 2013, ch. 257, § 1, p. 633.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 257, in subsection (1), substituted "that fails to pay a person entitled thereto within" for "which shall fail for a period of", inserted "or" following "certificate or contract", inserted "within sixty (60) days if the proof of loss pertains to uninsured motorist or underinsured motorist coverage benefits", inserted "that person is" following "the amount", and substituted "thereafter commenced" for "thereafter brought."

JUDICIAL DECISIONS

ANALYSIS

Amount Justly Due.

Merely offering the amount justly due does not constitute either paying it to the person entitled thereto or depositing it in the court. Likewise, sending the person entitled thereto a warrant or check with instructions not to negotiate the warrant or check does not constitute payment until there is permission to negotiate it. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Appeal Not Frivolous.

Subsection (4) authorizes an award of attorney fees if an appeal is brought frivolously: such as when an appellant is merely asking the supreme court to second-guess the district court's ruling, despite unambiguous controlling language in the insurance policy. Mortensen v. Stewart Title Guar. Co., 149 Idaho 437, 235 P.3d 387 (2010).

Insurer was not entitled to attorney fees, because the insured presented a legitimate question of law as to how "surface water" should be interpreted under the terms of his contract Rizzo v. State Farm Ins. Co., — Idaho —, 305 P.3d 519 (2013).

Arbitration.

Following the 2010 amendment of this section, an insured, who filed a petition to confirm an arbitration award, is entitled to an award for any attorney's fees incurred between the July 1 effective date of the amendment and the filing of the petition. Ferrell v. United Fin. Cas. Co., — Idaho —, 305 P.3d 529 (2013).

Attorney Fees.

Where appellant insured's suit against respondent insurance company for breach of an insurance contract and declaratory relief was dismissed and the supreme court upheld the decision, although the insurance company prevailed on appeal, subsection (4) of this section precluded an award of attorney fees. Villa Highlands, LLC v. Western Cmty. Ins. Co., 148 Idaho 598, 226 P.3d 540 (2010).

This section and § 12-123 are the exclusive remedies for obtaining attorney fees in insurance disputes. The award of fees was proper where the insured never raised any triable issues of fact and did not attempt to offer any factual evidence to support his claims that the title company acted without diligence or in bad faith when it sought to obtain for him an ownership interest in the access road, even though he demanded that the title company do something to ensure he had an easement there. Mortensen v. Stewart Title Guar. Co., 149 Idaho 437, 235 P.3d 387 (2010).

In a suit stemming from an insurer's bad faith failure to pay medical bills of its innocent insureds who were injured in an automobile collision, the trial court erred in awarding attorney fees under subsection (1) of this section based upon the insurer's failure to pay for an insured's future medical expenses or general damages because the insureds never submitted a proof of loss for such damages and, thus, failed to meet the condition precedent for an award of attorney fees for recovering those damages. Because the insureds only submitted claims for past medical services received and did not submit a claim for future medical expenses, the insurer did not act in bad faith in failing to pay future medical expenses. Weinstein v. Prudential Prop. & Cas. Ins. Co., 149 Idaho 299, 233 P.3d 1221 (2010).

Duty of Claimant.

If a party claims this section provides authority for an award of attorney's fees, the party must cite to the section and, if applicable, the specific subsection, upon which the party relies or attorney's fees will not be awarded. Rogers v. Household Life Ins. Co., 150 Idaho 735, 250 P.3d 786 (2011).

Justly Due.

Under this section, no amount is "justly due" until facts substantially indicative of the

uninsured motorist's liability are shown the insurer Jones v. State Farm Mut. Auto Ins. (In re Jones), 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

Prevailing Party.

Where appellant insured's suit for breach of an insurance contract and declaratory relief was dismissed, the insured was not the prevailing party and was not entitled to recover attorney fees under subsection (1) of this section or subsection (3) of § 12-120. Villa Highlands, LLC v. Western Cmty. Ins. Co., 148 Idaho 598, 226 P.3d 540 (2010).

Because an insurer had not paid any money to the insureds before suit was filed, nor had it tendered payment and paid the sum into court, the insureds were the prevailing parties under this section. Idaho R. Civ. P. 54(d)(1)(B) did not apply to determining the prevailing party because its requirement to compare the relief sought with the result obtained would be inconsistent with this section. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Proof of Loss.

A submitted proof of loss is sufficient when the insured provides the insurer with enough information to allow the insurer a reasonable opportunity to investigate and determine its liability and mentions a specific sum so that a tender can be made, or provides the basis for calculating the amount of the claimed loss. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

There is no requirement that a proof of loss include a theory of coverage. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Purpose.

The purpose of the statute is to provide an incentive for insurers to settle just claims in order to reduce the amount of litigation and the high costs associated with litigation and to prevent the sum that is due the insured under the policy from being diminished by expenditures for services of an attorney. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Summary Judgment Inapplicable.

An assertion that a party is entitled to attorney's fees under this section is not a claim for relief to which a summary judgment motion would be applicable. Attorney's fees are simply costs awarded incident to prevailing on a cause of action. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Surety.

By its plain meaning, subsection (3) was intended to hasten the resolution of consumers' claims and afford sureties a degree of discretion in settling undisputed claims. Hestead v. CNA Supply, 152 Idaho 575, 272 P.3d 547 (2012).

Time Limitation.

Because the thirty-day limit in subsection (1) is for the insured's benefit, the insured can agree to extend the time when the 30-day period begins to run or when it is deemed to expire. Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland), 153 Idaho 94, 279 P.3d 80 (2012).

Voluntary Payment.

Any right an insurer has to contest the amount "justly due" is waived upon its voluntary payment of a greater amount. Jones v. State Farm Mut. Auto Ins. (In re Jones), 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

Cited in: Hill v. Am. Family Mut. Ins. Co., 150 Idaho 619, 249 P.3d 812 (2011); Farm Bureau Mut. Ins. Co. v. Eisenman, 153 Idaho 549, 286 P.3d 185 (2012); Lakeland True Value Hardware, LLC v. Hartford Fire Ins. Co., 153 Idaho 716, 291 P.3d 399 (2012); Emplrs Mut. Cas. Co. v. Donnelly, 154 Idaho 499, 300 P.3d 31 (2013).

41-1848. Legislative findings and purpose — Coverage for abortions in state exchange prohibited. — (1) The legislature finds that:

(a) Pursuant to section 1303 of the patient protection and affordable care act, P.L. 111-148, states are explicitly permitted to pass laws prohibiting qualified health plans offered through an exchange in their state from offering abortion coverage;

(b) It is the longstanding policy of this state to prefer live childbirth over abortion and to prohibit the use of taxpayer moneys to fund abortions unless the mother's life is at risk or the pregnancy is a result of rape or incest;

(c) Idaho law prohibits certain insurance plans, policies and contracts issued in this state from offering coverage for elective abortions; and

(d) It is the purpose of this section to affirmatively prohibit qualified health plans that cover abortions from participating in exchanges within this state.

(2) Notwithstanding any other provision of law, no abortion coverage may be provided by a qualified health plan offered through an exchange created pursuant to the patient protection and affordable care act, P.L. 111-148, within the state of Idaho.

(3) The provisions of subsection (2) of this section shall not apply to an abortion performed if it is the recommendation of one (1) consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts.

History.
I.C., § 41-1848, as added by 2011, ch. 152, § 1, p. 436.

STATUTORY NOTES

Federal References.
P.L. 111-148, the patient protection and affordable care act, referred to in this section, is generally codified in title 42 of the United States Code. Section 1303 of the act, referred to in paragraph (1)(a), is codified as 42 USCS § 18023.

41-1850. Certificates of insurance. — (1) For purposes of this section, the following terms have the following meanings:

(a) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance, insurance binder, policy endorsement or automobile insurance identification card.

(b) "Certificate holder" means any person, other than a policyholder, that requests, obtains or possesses a certificate of insurance.

(c) "Insurance producer" has the same meaning as provided for in title 41, chapter 10, Idaho Code.

(d) "Insurer" has the same definition as provided for in section 41-103, Idaho Code.

(e) "Person" means any individual, partnership, corporation, association or other legal entity, including any government or governmental subdivision or agency.

(f) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

(g) "Group master policy" means an insurance policy that provides coverage to eligible persons on a group basis through a group insurance program.

(2) No person, wherever located, may prepare, issue or knowingly request the issuance of a certificate of insurance unless the form has been filed with the director by or on behalf of an insurer. No person, wherever located, may

alter or modify a certificate of insurance form unless the alteration or modification has been filed with the director.

(3) The director shall disapprove the use of any form filed under this section, or withdraw approval of a form, if the form:

(a) Is unfair, misleading or deceptive, or violates public policy;

(b) Fails to comply with the requirements of this section; or

(c) Violates any provision of title 41, Idaho Code, including any rule promulgated by the director.

(4) Each certificate of insurance must contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend the coverage, terms, exclusions and conditions afforded by the policies referenced herein."

(5) The current edition of standard certificate of insurance forms promulgated and filed with the director by the association for cooperative operations research and development (ACORD) or the insurance services office (ISO) are not required to be refiled by individual insurers.

(6) No person, wherever located, shall demand or request the issuance of a certificate of insurance or other document, record or correspondence that the person knows contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(7) No person, wherever located, may knowingly prepare or issue a certificate of insurance or other document, record or correspondence that contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(8) The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers and certificate of insurance forms issued as evidence of property or casualty insurance coverages on property, operations or risks located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located.

(9) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively alter, amend or extend the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance provides.

(10) No certificate of insurance shall contain references to contracts other than the underlying contracts of insurance, including construction or service contracts. Notwithstanding any requirement, term or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions and conditions of the policy itself.

(11) A person is entitled to receive notice of cancellation, nonrenewal or any material change or any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy or any endorsement to the policy. The terms and conditions of the notice, including

the required timing of the notice, are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

(12) Any certificate of insurance or any other document, record or correspondence prepared, issued or requested in violation of this section shall be null and void and of no force and effect.

(13) Any person who violates this section shall be subject to an administrative penalty imposed by the director in an amount as provided for in section 41-117, Idaho Code, per violation.

(14) The director shall have the power to examine and investigate the activities of any person that the director believes has been or is engaged in an act or practice prohibited by this section. The director shall have the power to enforce the provisions of this section and impose any authorized penalty or remedy against any person who violates this section.

(15) The director may, in accordance with section 41-211, Idaho Code, adopt reasonable rules as are necessary or proper to carry out the provisions of this section.

(16) This section shall not apply to any certificate of insurance prepared and/or issued by an insurer pursuant to any federal law, rule or regulation, or any other law, rule or regulation of this state, in which the specific content and form of said certificate is enumerated therein, or a certificate issued to a person or entity that has purchased coverage under a group master policy.

History.
I.C., § 41-1850, as added by 2012, ch. 314, § 1, p. 863.

STATUTORY NOTES

Compiler's Notes.
Section 3 of S.L. 2012, ch. 314 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

The words enclosed in parentheses so appeared in the law as enacted.

41-1851. Electronic notices and documents. — (1) In this section, the following words shall have the following meanings:

(a) "Delivered by electronic means" includes:

(i) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(ii) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice to a party directed to the electronic mail address at which the party has consented to receive notice of the posting;

(iii) Delivery or posting directly to a mobile device or other electronic device accessible by a party that has consented to conduct insurance transactions electronically.

(b) "Party" means any recipient of any notice or document required as part of an insurance transaction including, but not limited to, an applicant, an insured, a policyholder or an annuity contract holder.

(2) Pursuant to subsection (4) of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored and presented by electronic means so long as it meets the requirements of the uniform electronic transactions act, chapter 50, title 28, Idaho Code.

(3) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including: delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

(4) A notice or document may be delivered by electronic means by an insurer to a party under this section if the party has affirmatively consented to that method of delivery and has not withdrawn the consent.

(5) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(6) If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt. In the absence of verification or acknowledgment of receipt, the insurer shall mail a paper copy of the notice or document within three (3) days via United States mail.

(7) The legal effectiveness, validity or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party.

(8)(a) A withdrawal of consent by a party does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(b) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(9) The provisions of this section do not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this act to a party who, before that date, has consented to receive notice or document in an electronic form otherwise allowed by law.

(10) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this act, and pursuant to the provisions of this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically the insurer shall notify the party of:

(a) The notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means.

(11)(a) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may

qualify as a notice or document delivered by electronic means for the purposes of this section.

(b) If a provision of this title or applicable law requires a signature or notice or document to be notarized, acknowledged, verified or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice or document.

(12) The provisions of this section may not be construed to modify, limit or supersede the provisions of the federal electronic signatures in global and national commerce act, P.L. 106-229, as amended.

History.
I.C., § 41-1851, as added by 2013, ch. 269, § 1, p. 697.

STATUTORY NOTES

Federal References.
The federal electronic signatures in global and national commerce act, P.L. 106-229, is codified as 15 U.S.C.S. § 7001 et seq.

Compiler's Notes.
The phrase "the effective date of this act" in subsection (10) refers to the effective date of S.L. 2013, ch. 269, which was effective July 1, 2013.

CHAPTER 19

LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS

41-1941. Annuity sales to consumers — Disclosures. — (1) In this section, the following definitions shall apply unless the context otherwise requires:

(a) "Contract owner" means the owner named in the annuity contract or certified holder in the case of a group annuity contract.

(b) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and that are not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements may include the premiums, credited interest rates (including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these. An element is considered determinable if it is calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(c) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity."

(d) "Guaranteed elements" means the premiums, credited interest rates

(including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these, that are promised and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(e) "Insurance producer" or "producer" has the same meaning as in chapter 10, title 41, Idaho Code.

(f) "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and that are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(g) "Structured settlement annuity" means a qualified funding asset as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) of the Internal Revenue Code but for the fact that it is not owned by an assignee under a qualified assignment.

(2) The provisions of this section shall apply to all group and individual annuity contracts and certificates except:

(a) Registered or nonregistered variable annuities or other registered products;

(b) Immediate and deferred annuities that contain no nonguaranteed elements;

(c) Annuities used to fund:

(i) An employee pension plan that is covered by the employee retirement income security act of 1974, title 29, U.S.C. sections 1001 through 1461;

(ii) A plan described in section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of the employee retirement income security act of 1974, is established or maintained by an employer;

(iii) A governmental or church plan as defined in section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization pursuant to section 457 of the Internal Revenue Code; or

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(d) Structured settlement annuities.

(3) If the application for an annuity contract is taken in a face-to-face meeting, the applicant, at or before the time of application, shall be given both the disclosure document and the buyer's guide in the form prescribed by the director. The disclosure document shall be dated and signed by the prospective annuity owner and producer and the company shall maintain a signed copy for the life of the contract.

(4) If the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer's guide in the manner and form prescribed by the director no later than five (5) business days after the completed application is received by the insurer.

(5) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurer for a free annuity buyer's guide.

(6) If the disclosure document and buyer's guide are not provided at or before the time of application, a free look period of not less than twenty (20) days shall be provided for the applicant to return the annuity contract without penalty. This free look period shall run concurrently with any other free look period provided in statute.

(7) At minimum, the following information shall be included in the disclosure document required to be provided under this section:

(a) The generic name of the contract, the company product name, if different, the form number and the fact that it is an annuity;

(b) The insurer's name and address;

(c) A description of the contract and its benefits, emphasizing its long-term nature and including the following examples where appropriate:

(i) The guaranteed, nonguaranteed and determinable elements of the contract, their limitations, if any, and an explanation of how they operate;

(ii) An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(iii) The periodic income options both on a guaranteed and nonguaranteed basis;

(iv) Any value reductions caused by withdrawals from or surrender of the contract;

(v) How values in the contract can be accessed;

(vi) The death benefit, if available, and how it will be calculated;

(vii) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(viii) The impact of any rider, such as a long-term care rider.

(d) The specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply;

(e) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change;

(f) Whenever projections for nonguaranteed elements of a contract are provided in the disclosure document, equal prominence shall be given to guaranteed elements; and

(g) Terms used in the disclosure document shall be defined in clear and concise language that facilitates the understanding of a typical person within the segment of the public to which the disclosure document is directed.

(8) For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract. Such report shall contain at minimum the following information:

(a) The beginning and end dates of the current report period;

(b) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

(c) The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

(d) The amount of outstanding loans, if any, as of the end of the current report period.

(9) The director may promulgate rules pursuant to this section including, but not limited to, more fully implementing model rules or laws developed by the national association of insurance commissioners that provide standards for the disclosure of certain minimum information in connection with the sale of annuity contracts.

(10) Nothing in this section shall be construed to create or imply a private cause of action for a violation of the provisions of this section or rules promulgated pursuant to this section.

History.

I.C., § 41-1941, as added by 2010, ch. 238, § 1, p. 617; am. 2012, ch. 107, § 6, p. 284.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 107 inserted "or" in paragraph (8)(c).

Federal References.

Section 130(d) of the Internal Revenue Code, referred to in paragraph (1)(g), is codified as 26 USCS § 130(d).

Sections 401(a), 401(k) and 403(b) of the Internal Revenue Code, referred to in paragraph (2)(c)(ii), are codified as 26 USCS §§ 401(a), 401(k), and 403(b).

Sections 414 and 457 of the Internal Revenue Code, referred to in paragraph (2)(c)(iii), are codified as 26 USCS §§ 414 and 457.

41-1951. Definitions. — In sections 41-1950 through 41-1965, Idaho Code:

(1) "Advertising" means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy pursuant to a life settlement contract.

(2) "Business of life settlements" means an activity involved in, but not limited to, the offering to enter into, soliciting, negotiating, procuring or effectuating a life settlement contract. The transaction of the business of life settlements is within the scope of the transaction of the business of insurance as provided in section 41-112, Idaho Code.

(3) "Chronically ill" means:

(a) Being unable to perform at least two (2) activities of daily living such as eating, toileting, transferring, bathing, dressing or continence; or

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(4) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a life settlement provider, credit enhancer or any entity that has a direct

ownership in a policy or certificate that is the subject of a life settlement contract, but:

(a) Whose principal activity related to the transaction is providing funds to effect the life settlement or purchase of one (1) or more settled policies; and

(b) Who has an agreement in writing with one (1) or more licensed life settlement providers to finance the acquisition of life settlement contracts.

"Financing entity" does not include a nonaccredited investor. An "accredited investor" is defined by rule 501 of regulation D, 17 CFR 230.501(a).

(5) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to section 41-1008, Idaho Code.

(6) "Life settlement broker" or "broker" means a person who, working exclusively on behalf of an owner and for a fee, commission or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and one (1) or more life settlement providers or one (1) or more life settlement brokers. Notwithstanding the manner in which the life settlement broker is compensated, a life settlement broker is deemed to represent only the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner. Nothing in this definition reduces or impairs the scope of the definitions in section 30-14-102, Idaho Code, including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. The term does not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the life settlement provider or purchaser.

(7) "Life settlement contract" means an agreement between an owner and a life settlement provider or any affiliate, as that term is defined in section 41-3802(1), Idaho Code, of the life settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the owner's present or future assignment, transfer, sale, hypothecation, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. Nothing in this definition reduces or impairs the scope of the definition of security contained in section 30-14-102(28), Idaho Code.

(a) "Life settlement contract" includes a premium finance loan made for a life insurance policy on or before the date of issuance of the policy where one (1) or more of the following conditions apply:

(i) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(ii) The owner or the insured receives on the date of the premium finance loan a guarantee of a future life settlement value of the policy; or

(iii) The owner or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(b) "Life settlement contract" includes the transfer, for compensation or value, of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other person was formed or availed of for the principal purpose of acquiring one (1) or more life insurance policies which life insurance contract insures the life of a person residing in this state.

(c) "Life settlement contract" does not include any of the following:

(i) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(ii) A loan, the proceeds of which are used solely to pay:

(A) Premiums for the policy; and

(B) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(iii) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default itself nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under sections 41-1950 through 41-1965, Idaho Code;

(iv) A loan made by a lender that does not violate the Idaho credit code, provided that the premium finance loan is not described in paragraph (a) of this subsection;

(v) An agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement:

(A) Between one (1) or more shareholders in a corporation or between a corporation and one (1) or more of its shareholders or one (1) or more trusts established by its shareholders;

(B) Between one (1) or more partners in a partnership or between a partnership and one (1) or more of its partners or one (1) or more trusts established by its partners; or

(C) Between one (1) or more members in a limited liability company or between a limited liability company and one (1) or more of its members or one (1) or more trusts established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction or arrangement exempted from the definition of life settlement contract by the director based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by sections 41-1950 through 41-1965, Idaho Code.

(8) "Life settlement provider" or "provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner resident in this state. Nothing in this definition reduces or impairs the scope of the definitions of section 30-14-102, Idaho Code, including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. "Life settlement provider" does not include:

(a) A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan;

(b) A premium finance company making premium finance loans that takes an assignment of a life insurance policy solely as collateral for a loan;

(c) The insurer of the life insurance policy;

(d) An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a life settlement provider, purchaser, financing entity, special purpose entity or related provider trust;

(e) A financing entity;

(f) A special purpose entity;

(g) A related provider trust; or

(h) Any other person that the director determines is not the type of person intended to be covered by the definition of life settlement provider.

(9) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a life settlement contract. For the purposes of sections 41-1950 through 41-1965, Idaho Code, an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed.

(a) If there is more than one (1) owner on a single policy and the owners are residents of different states, the transaction shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one (1) owner agreed upon in writing by all the owners.

(b) "Owner" does not include:

(i) A licensee under sections 41-1950 through 41-1965, Idaho Code, including a life insurance producer acting as a life settlement broker pursuant to sections 41-1950 through 41-1965, Idaho Code;

(ii) Qualified institutional buyer as defined, respectively, in rule 144A, 17 CFR 230.144A, promulgated under the federal securities act of 1933, 15 USC section 77a et seq., as amended;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust.

(10) "Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(11) "Premium finance loan" means a loan made primarily for the purpose of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(12) "Related provider trust" means a titling trust or other trust established by a licensed life settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed life settlement provider under which the licensed life settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to life settlement transactions available to the director as if those records and files were maintained directly by the licensed life settlement provider.

(13) "Settled policy" means a life insurance policy or certificate that has been acquired by a life settlement provider pursuant to a life settlement contract.

(14) "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

(a) For a financing entity or licensed life settlement provider;

(b) In connection with a transaction in which the securities in the special purposes entity are acquired by the owner or by "qualified institutional buyers" as defined in rule 144A, 17 CFR 230.144A, promulgated under the federal securities act of 1933, as amended; or

(c) In connection with a transaction in which the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(15) "Stranger-originated life insurance" or "STOLI" means an act, plan, practice, or arrangement to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether oral or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of an insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in subsection (7)(c) of this section.

(16) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death within twenty-four (24) months or less.

History.
I.C., § 41-1951, as added by 2009, ch. 69, § 1, p. 192; am. 2013, ch. 266, § 10, p. 652.

STATUTORY NOTES

Cross References.
Idaho credit code, § 28-41-101 et seq.

Amendments.
The 2013 amendment, by ch. 266, updated the first statutory reference in the introductory paragraph in subsection (7) in light of the revision of chapter 38, title 41, Idaho Code; deleted "consumer" preceding "credit code" in paragraph (7)(c)(iv); and substituted "rule 144A, 17 CFR 230.144A, promulgated under" for "rule 144 of" in paragraph (14)(b).

CHAPTER 23

CREDIT LIFE AND CREDIT DISABILITY INSURANCE

41-2307. Term of credit life insurance and credit disability insurance.

JUDICIAL DECISIONS

Contract Formation.
Insurer was not required to extend credit life insurance coverage on the date the loan closed without first approving the application; thus, because the application's language made clear that it might not be approved and the insurer did not approve it, no contract was formed. Shapley v. Centurion Life Ins. Co., 154 Idaho 875, 303 P.3d 234 (2013).

41-2308. Provisions of policies and certificates of insurance — Disclosure to debtors.

JUDICIAL DECISIONS

Policy Delivery.
Insurer was not required to extend credit life insurance coverage on the date the loan closed without first approving the application; thus, no contract was formed absent approval, and the insurer was not required to deliver a policy. Because the premium payments were separate from the loan payments, the insurer fully complied with this section by providing the applicants with a copy of their insurance application and a notice of insurance underwriting practices. Shapley v. Centurion Life Ins. Co., 154 Idaho 875, 303 P.3d 234 (2013).

CHAPTER 25

CASUALTY INSURANCE CONTRACTS

41-2502. Uninsured motorist and underinsured motorist coverage for automobile insurance — Exceptions.

JUDICIAL DECISIONS

Exhaustion Clauses.
Because the exhaustion clause in the insured's policy with the insurer violated public policy, it could not bar her recovery for uninsured motorists benefits. Under this section, claimants need not exhaust the limits of the

tortfeasor's policy, but instead had to credit to the UIM insurer the gap between the settlement with the tortfeasor's insurer, if any, and the policy limits. Hill v. Am. Family Mut. Ins. Co., 150 Idaho 619, 249 P.3d 812 (2011).

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

A.L.R. — Validity, construction, and application of exhaustion clause of underinsured motorist coverage plan. 75 A.L.R.6th 235.

Application of uninsured or underinsured motorist or no-fault insurance to school bus incidents. 80 A.L.R.6th 389.

41-2507. Cancellation of policies — Grounds. — No notice of cancellation of a policy shall be effective and the insurer shall not refuse renewal of a policy, unless based on one (1) or more of the following reasons:

(1) Nonpayment of premium; or

(2) The policy was obtained through a material misrepresentation; or

(3) Any insured violated any of the terms and conditions of the policy; or

(4) The named insured failed to disclose fully his motor vehicle accidents and moving traffic violations, or his losses covered under any automobile physical damage or comprehensive coverage, for the preceding thirty-six (36) months if called for in the application; or

(5) As to renewal of the policy, if the insured at any time while the policy was in force failed to disclose fully to the insurer, upon request therefor, facts relative to accidents and losses incurred material to underwriting of the risk; or

(6) Any insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim; or

(7) The named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy:

(a) Has, within the thirty-six (36) months prior to the notice of cancellation or nonrenewal, had his driver's license under suspension or revocation; or

(b) Has a history of and is subject to epilepsy or heart attacks and such individual cannot produce a certificate from a physician testifying to his unqualified ability to operate a motor vehicle safely; or

(c) Has an accident record, conviction record, either criminal or traffic, physical, mental or other condition which is such that his operation of an automobile might endanger the public safety; or

(d) Has, while the policy is in force, engaged in a prearranged competitive speed contest while operating or riding in an automobile insured under the policy; or

(e) Has, within the thirty-six (36) months prior to the notice of cancellation or nonrenewal, been addicted to the use of narcotics or other drugs; or

(f) Uses alcoholic beverages to excess; or

(g) Has been convicted, or forfeited bail, during the thirty-six (36) months immediately preceding the notice of cancellation or nonrenewal; for

(i) Any felony; or

(ii) Criminal negligence resulting in death, homicide or assault arising out of the operation of a motor vehicle; or

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs; or

(iv) Leaving the scene of an accident without stopping to report; or

(v) Theft or unlawful taking of a motor vehicle; or

(vi) Making fraudulent statements in an application for a driver's license; or

(h) Has been convicted of, has had a judgment entered against, or forfeited bail for, three (3) or more violations within the thirty-six (36) months immediately preceding the notice of cancellation or nonrenewal of any law, ordinance or regulation of any state for which a violation point is assessed by the Idaho transportation department under the provisions of section 49-326, Idaho Code, whether or not the violations were repetitions of the same offense or different offenses; or

(8) The insured automobile is:

(a) So mechanically defective that its operation might endanger public safety; or

(b) Used in carrying passengers for hire or compensation, except that the use of an automobile for a carpool shall not be considered use of an automobile for hire or compensation; or

(c) Used in the business of transportation of flammables or explosives; or

(d) An authorized emergency vehicle; or

(e) Modified or changed in condition during the policy period so as to increase the risk substantially; or

(f) Subject to an inspection law and has not been inspected or, if inspected, has failed to qualify; or

(9) As to the renewal of the policy only, the insured automobile is registered in a jurisdiction other than Idaho.

History.
I.C., § 41-2507, as added by 1969, ch. 214, § 60, p. 625; am. 1992, ch. 250, § 1, p. 734; am. 2013, ch. 56, § 1, p. 130.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 56, added subsection (9).

41-2511. Deductible — Permissive. — Nothing in sections 41-2506 through 41-2512, Idaho Code, shall prohibit, or be construed to prohibit, an insurer from requiring a provision for a reasonable deductible not exceeding two hundred fifty dollars ($250) in amount as to comprehensive coverage and not exceeding five hundred dollars ($500) in amount as to collision or physical damage coverages of the policy, as a condition to renewal of an automobile insurance policy.

History.
I.C., § 41-2511, as added by 1969, ch. 214, § 64, p. 625; am. 1991, ch. 312, § 1, p. 819; am. 2012, ch. 90, § 1, p. 253.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 90, substituted "two hundred fifty dollars ($250) in amount as to comprehensive coverage and not exceeding five hundred dollars ($500)" for "one hundred fifty dollars ($150) in amount as to comprehensive coverage and not exceeding three hundred dollars ($300)".

CHAPTER 27

TITLE INSURANCE

41-2705. Supervision — Policy forms — Premiums. — (1) The business of title insurance shall operate in Idaho under the control and supervision of the director of the department of insurance as to the premium rates for basic classifications of policy and underwriting contracts in relation thereto, escrow fee, rates, tract indexes and abstract records, and insurability as provided in title 41, Idaho Code, and under such uniform rules and regulations as may be from time to time prescribed by the director of the department of insurance. No title insurer shall engage in the title insurance business with respect to any interest in Idaho property other than under the applicable laws of the state of Idaho and under such rules and regulations as may be issued by the director of the department of insurance. No policy of title insurance or guarantee of any character on Idaho property shall be issued unless written by a title insurer complying with all the provisions of the laws of the state of Idaho, holding a certificate of authority under chapter 3, title 41, Idaho Code, and under such rules and regulations as may be issued by the director of the department of insurance.

(2) The rates for the premiums for title insurance, the proportion of the premium for title insurance which is retained by a title insurance agent and the portion which is retained by a title insurer, shall be determined within the provisions of sections 41-2706, 41-2707 and 41-2708, Idaho Code, and the general provisions of title 41, Idaho Code; provided, not later than the effective date hereof each title insurer shall file its premium rates and basic policy classification in relation thereto, and the said rate so filed shall continue until changed as herein provided.

(3) The escrow fees of title insurers and title insurance agents shall be filed in accordance with rules promulgated by the director of the department of insurance.

(4) A title insurer shall file each form of certificate, policy, preliminary report, binder, guaranty or other underwriting contract of title insurance prior to the delivery or issuance thereof in Idaho. The filing of the form of policies and contracts of title insurance and the approval of the same shall be in accordance with sections 41-1812 and 41-1813, Idaho Code, as well as in conformance with chapter 27, title 41, Idaho Code.

(5) The provisions of sections 41-2705 through 41-2708, Idaho Code, shall not apply to a title insurer contracting as a reinsurer of a title insurance policy on Idaho property where no primary liability is assumed.

(6) The director of the department of insurance, for the purpose of carrying out this chapter shall have the right to require title insurers issuing policies in Idaho and title insurance agents to submit such information as needed as to expense of operations, loss experience, underwriting risks and other material matters.

(7) Any person aggrieved by any order, act or regulation of the director hereunder shall have the rights and remedies set forth in chapter 52, title 67, Idaho Code.

History.

I.C., § 41-2705, as added by 1973, ch. 135, § 2, p. 252; am. 2011, ch. 195, § 1, p. 556.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 195, added the subsection designations; in subsection (2), deleted "and the escrow fees of title insurers and title insurance agents" following "by a title insurer," deleted "and each title insurer and title insurance agent shall file its escrow fee, in effect on January 1, 1973" following "relation thereto," and deleted "and fee" following "the said rate"; and added subsection (3).

JUDICIAL DECISIONS

Class Actions.

In considering a borrower's Fed. R. Civ. P. 23 motion for class certification in an action alleging violation of this section and § 41-2707, the magistrate judge properly found that the borrower met the prerequisites for class certification; individual issues did not predominate because, although examining each class member's file was necessary, this was an almost automatic process to determine whether the title policy showed a prior mortgage and whether the person received the discounted rate for a refinanced residential mortgage. Lewis v. First Am. Title Ins. Co., 265 F.R.D. 536 (D. Idaho 2010).

41-2706. Title insurance rates — Justification. — Title insurance premium rates for the basic classification of policies and underwriting contracts shall be those filed by a title insurer or a title insurance rating organization with justification and approved by order of the director of the department of insurance, or, those filed by the director of the department of insurance with his justification therefor, hearing thereon and order of the director, both as more particularly hereinafter set forth. The division of the total premium between a title insurer and a title insurance agent shall be filed by the title insurer. The insurance premium rates on basic classification of policies and said division of total premium shall be deemed fixed by the director of the department of insurance upon the director's order approving the same (i) as filed and justified by a title insurer or title insurance rating organization, with or without hearing, or (ii) following a hearing on the same as filed and justified by the director of the department of insurance.

(1) Justification of title insurance rates proposed by a title insurer, a title insurance rating organization, or the director of the department of insurance shall be filed with any proposed change of rate, and the filing shall be justified by:

(a) the experience or judgment of the title insurer or title insurance rating organization or the director proposing the rates; or

(b) its interpretation of any statistical data relied upon; or

(c) the experience of other title insurers or title insurance rating organizations; or

(d) any other factors which the title insurer or rating organization or director deems relevant.

(2) Rates made hereunder shall not be excessive, nor inadequate for the safety and soundness of the title insurer and title insurance agent, and shall not be unfairly discriminatory, and shall be adopted giving due consideration to:

(a) desirability of stability of rate structures;

(b) necessity of assuring the financial solvency of a title insurer and title insurance agent in periods of economic depression by encouraging growth in assets of title insurers and title insurance agents in periods of high business and activity; and

(c) necessity for assuring a reasonable margin of underwriting profit sufficient to induce capital to be invested therein.

(3) Every title insurer and every title insurance rating organization shall adopt basic classifications of policies and contracts of title insurance which shall be used as the basis for rates. Rates for each classification may, at the discretion of the title insurer, or the title insurance rating organization filing the rate, be less than the cost of the expense elements in the case of smaller insurances, and the excess may be charged against larger insurances without rendering the rate unfairly discriminatory.

(4) When the director finds upon application by a title insurer that any rate for a particular kind or class of risk cannot practicably be filed before it is used, or any contract or kind of title insurance, by reason of rarity or peculiar circumstances, does not lend itself to advance determination and filing of rates, he may, under such rules and regulations as he may prescribe, permit such rate or contract or kind of title insurance to be used without a previous notice and thirty (30) day waiting period.

History.

I.C., § 41-2706, as added by 1973, ch. 135, § 3, p. 252; am. 2011, ch. 195, § 2, p. 556.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 195, in the first paragraph, deleted "and the escrow, closing or settlement fees shall be filed by the title insurer or agent as applicable and approved in the same manner as title insurance premiums" from the end of the second sentence and deleted "and said escrow fees" following "total premium" and "or title insurance agent" following "insurance rating organization" in the last sentence.

CHAPTER 28

ORGANIZATION AND CORPORATE PROCEDURES OF STOCK AND MUTUAL INSURERS

SECTION.

41-2857. Mergers and consolidations of mutual insurers. — (1) Except as set forth in section 41-3824, Idaho Code, a domestic mutual insurer shall not merge or consolidate with a stock insurer.

(2) A domestic mutual insurer may merge or consolidate with another mutual insurer under the applicable procedures prescribed by the statutes of this state applying to corporations formed for profit, except as hereinbelow provided.

(3) The plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds (2/3) of the members of each mutual insurer voting thereon at meetings called for the purpose pursuant to such reasonable notice and procedure as has been approved by the director. If a life insurer, right to vote may be limited to members whose policies are other than term and group policies and have been in effect for more than one (1) year.

(4) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the director and approved by him in writing after a hearing thereon. The director shall give such approval within a reasonable time after such filing unless he finds such plan or agreement:

(a) Inequitable to the policyholders of any domestic insurer involved; or

(b) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere; or

(c) Is subject to other material and reasonable objections.

(5) If the director does not approve such plan or agreement, he shall so notify the insurers in writing specifying his reasons therefor.

(6) No director, officer, agent or employee of any insurer party to such merger or consolidation, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in the plan and agreement approved by the director.

History.
1961, ch. 330, § 625, p. 645; am. 1998, ch. 303, § 2, p. 1001; am. 2013, ch. 266, § 11, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated the reference in subsection (1) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

CHAPTER 32

FRATERNAL BENEFIT SOCIETIES

SECTION.

41-3239. Other provisions applicable. [Effective January 1, 2015.] — (1) Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, not only in governmental relations with this state, but for every other purpose, and no law hereafter enacted shall apply to them, unless expressly designated therein.

(2) The following chapters and provisions of this code shall also apply to fraternal benefit societies (who for the purpose shall be deemed also to be "insurers") to the extent so applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of such express provisions:

(a) Chapter 1[, title 41, Idaho Code] (scope of code);

(b) Chapter 2[, title 41, Idaho Code] (the director of insurance);

(c) Section 41-308(2)[, Idaho Code] (general eligibility for certificate of authority), and for the purpose the annual license of a fraternal benefit society is deemed to be its "certificate of authority";

(d) Sections 41-1201[, Idaho Code] (representing or aiding unauthorized insurer prohibited), 41-1202[, Idaho Code] (penalty), and 41-1203[, Idaho Code] (suits by unauthorized insurer prohibited);

(e) The following sections of chapter 18[, title 41, Idaho Code] (the insurance contract):

(i) Section 41-1828[, Idaho Code] (payment discharges insurer — payment to marital community);

(ii) Section 41-1829[, Idaho Code] (minor may give acquittance);

(iii) Section 41-1830[, Idaho Code] (life policy as separate property of married woman);

(iv) Section 41-1838[, Idaho Code] (venue of suits against insurers);

(v) Section 41-1839[, Idaho Code] (allowance of attorney fees in suits against insurers);

(f) Section 41-1934[, Idaho Code] (prohibited policy plans);

(g) Section 41-2837[, Idaho Code] (prohibited pecuniary interest of officials);

(h) Chapter 33[, title 41, Idaho Code] (rehabilitation and liquidation);

(i) Section 41-332[, Idaho Code] (foreign insurers exempt from corporation laws governing admission of foreign corporations);

(j) Section 41-2141[, Idaho Code] (coordination with social security benefits);

(k) Section 41-1927A[, Idaho Code] (standard nonforfeiture law for individual deferred annuities);

(*l*) Chapter 46[, title 41, Idaho Code] (long-term care insurance); and

(m) Chapter 54[, title 41, Idaho Code] (risk-based capital).

History.
I.C., § 41-3239, as added by 1995, ch. 213, § 2, p. 722; am. 2014, ch. 319, § 7, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, added paragraph (2)(m).

Compiler's Notes.
For this section as effective until January 1, 2015, see the bound volume.

Section 41-1829 referred to in subsection (2)(e)(ii) of this section was repealed by S.L. 1972, ch. 241, § 1.

Chapter 33 (Rehabilitation and Liquidation), referred to in subsection (2)(h), was repealed by S.L. 1981, ch. 249 and replaced by a new chapter 33, title 41, Idaho Code (Insurers Supervision, Rehabilitation and Liquidation).

The bracketed insertions were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.
Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

CHAPTER 33

INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION

41-3312. Grounds for rehabilitation. — The director may apply by petition to the district court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one (1) or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the director to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the director concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to

terminate the employment and status of the person and all his influence on management.

(6) After demand by the director under the provisions of section 41-223, Idaho Code, under this act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(7) Without first obtaining the written consent of the director, the insurer has transferred, or attempted to transfer, in a manner contrary to chapter 38, title 41, Idaho Code, or sections 41-2856 and 41-2858, Idaho Code, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this act.

(9) Within the previous six (6) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the director under the provisions of section 41-3309, Idaho Code.

(10) The insurer has failed to pay within sixty (60) days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the director or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the director, has failed to give an adequate explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in section 41-3802, Idaho Code, request or consent to rehabilitation under this act.

History.
I.C., § 41-3312, as added by 1981, ch. 249, § 2, p. 502; am. 2013, ch. 266, § 12, p. 652.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 266, updated the reference in subsection (12) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.
The term "this act" in subsections (6), (8), and (12) refers to S.L. 1981, ch. 249, which is compiled as §§ 41-3301 to 41-3360.

41-3345. Unclaimed and withheld funds. — (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with section 41-3342, Idaho Code, to the person entitled thereto or his legal representative upon proof satisfactory to the state treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the state treasurer pursuant to chapter 5, title 14, Idaho Code.

(2) All funds withheld under section 41-3337, Idaho Code, and not distributed shall upon discharge of the liquidator be deposited with the state treasurer and paid by him in accordance with section 41-3342, Idaho Code. Any sums remaining which under section 41-3342, Idaho Code, would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection (1) hereof, unless the director in his discretion petitions the court to reopen the liquidation under section 41-3347, Idaho Code.

History.
I.C., § 41-3345, as added by 1981, ch. 249, § 2, p. 502; am. 2011, ch. 151, § 23, p. 414.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 151, substituted "state treasurer" for "tax collector" in the last sentence in subsection (1).

CHAPTER 34

HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS

SECTION.

41-3434. Other provisions applicable. [Effective January 1, 2015.] — In addition to those contained or referred to heretofore in this chapter, the following chapters and provisions of this code shall also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of such

express provisions, and for the purposes of such application such corporations shall be deemed to be mutual "insurers":

(1) Chapter 1[, title 41, Idaho Code] (scope of code);

(2) Chapter 2[, title 41, Idaho Code] (the director of insurance);

(3) Section 41-308(2)[, Idaho Code] (general eligibility for certificate of authority — competence, affiliations of management);

(4) Sections 41-345 through 41-347[, Idaho Code] (disclosure of material transactions);

(5) Section 41-601[, Idaho Code] ("assets" defined);

(6) Section 41-603[, Idaho Code] (assets not allowed);

(7) Section 41-604[, Idaho Code] (disallowance of "wash" transactions);

(8) Section 41-613[, Idaho Code] (valuation of bonds);

(9) Section 41-731[, Idaho Code] (prohibited investments and investment underwriting);

(10) Chapter 13[, title 41, Idaho Code] (trade practices and frauds);

(11) Section 41-2840[, Idaho Code] (vouchers for expenditures);

(12) Section 41-2841[, Idaho Code] (borrowed surplus);

(13) Sections 41-2857[, Idaho Code] (mergers and consolidations, mutual insurers), 41-2858[, Idaho Code] (bulk reinsurance, mutual insurers), and 41-2859[, Idaho Code] (mutual member's share of assets on liquidation);

(14) Chapter 33[, title 41, Idaho Code] (supervision, rehabilitation and liquidation);

(15) Sections 799 to 809 of chapter 330 of Session Laws of 1961 (transitory provisions);

(16) Section 41-2106(3)[, Idaho Code] (health history application for disability insurance);

(17) Section 41-2141[, Idaho Code] (coordination of benefits — coordination with social security benefits);

(18) Section 41-1839[, Idaho Code] (attorney fees);

(19) Chapter 46[, title 41, Idaho Code] (long-term care insurance);

(20) Section 41-1844[, Idaho Code] (prescription drug benefit restrictions prohibited);

(21) Section 41-2216[, Idaho Code] (coordination of benefits — coordination with social security benefits); and

(22) Chapter 54[, title 41, Idaho Code] (risk-based capital).

History.

1961, ch. 330, § 792, p. 645; am. 1976, ch. 135, § 2, p. 507; am. 1978, ch. 10, § 4, p. 19; am. 1988, ch. 8, § 1, p. 10; am. 1990, ch. 285, § 4, p. 792; am. 1991, ch. 123, § 2, p. 268; am. 1994, ch. 404, § 3, p. 1268; am. 1995, ch. 68, § 4, p. 173; am. 1997, ch. 319, § 3, p. 942; am. 2003, ch. 304, § 13, p. 833; am. 2014, ch. 319, § 8, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, added subsection (22).

Compiler's Notes.

For this section as effective until January 1, 2015, see the bound volume.

The bracketed insertions were added by the compiler to conform to the statutory citation style.

The word enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that

the act should take effect on and after January 1, 2015.

CHAPTER 36

INSURANCE GUARANTY ASSOCIATION

41-3608. Obligations and powers of association. — (1) The association shall:

(a) Be obligated to pay covered claims existing prior to the order of liquidation arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the order of liquidation. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a worker's compensation insurance coverage;

(ii) An amount not exceeding ten thousand dollars ($10,000) per policy for covered claim for the return of unearned premium;

(iii) An amount not exceeding three hundred thousand dollars ($300,000) per claim for all other covered claims.

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the association after the earlier of: (i) eighteen (18) months after the date of the order of liquidation, or (ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and shall not include any claim filed with the association or a liquidator for protection afforded under the insured policy for incurred-but-not-reported losses. Any obligation of the association to defend an insured shall cease upon the association's payment by settlement releasing the insured or on a judgment of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

(c) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent including, but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations.

(d) Assess member insurers separately for amounts necessary to pay the obligations of the association under paragraph (a) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this chapter. The assessments of each member insurer shall be in the propor-

tion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance covered by the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance covered by the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one (1) year an amount greater than one percent (1%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association in the account, does not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order which it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account.

(e) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested. The association shall have the right to appoint or substitute and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

(f) Handle claims through its employees or through one (1) or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the director, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this chapter.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

(c) Sue or be sued, and such power to sue includes the power and right to intervene as a party before any court that has jurisdiction over the insolvent insurer as defined by this chapter.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this chapter.

(e) Perform such other acts as are necessary or proper to effectuate the purpose of this chapter.

(f) Refund to the member insurers in proportion to the contribution of each member insurer that amount which, in the opinion of the board of directors, will not be needed for the purposes of this chapter within two (2) years from the date the association receives the refund from the receivership.

(g) Subject to approval by the director, provide claims handling services to any run-off insurer, provided the association expenses related to such services are fully reimbursed. Normal defenses applicable to guaranty fund handling of covered claims shall not apply to run-off claim handling and no guaranty fund assets shall be used for run-off claim or expense payment. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the association or its agents or employees, the board of directors or any person serving as a representative of any director for any action taken or any failure to act by them in the performance of their activities under the provisions of this paragraph. For purposes of this paragraph, "run-off insurer" means a property and casualty insurer that has:

(i) Total adjusted capital under risk-based capital requirements in an amount less than the authorized control level risk-based capital as defined in section 41-5401(11)(a), Idaho Code, and has indicated that it will cease writing new insurance policies, either as part of its corrective action plan or pursuant to being placed under regulatory control; or

(ii) Total adjusted capital under risk-based capital requirements in an amount less than the mandatory control level risk-based capital as defined in section 41-5401(11)(c), Idaho Code, and that has not been placed into liquidation pursuant to sections 41-3317 and 41-3318, Idaho Code.

History.

1970, ch. 152, § 8, p. 462; am. 1980, ch. 275, § 1, p. 718; am. 1984, ch. 66, § 1, p. 115; am. 1992, ch. 316, § 3, p. 942; am. 1993, ch. 279, § 1, p. 943; am. 1997, ch. 109, § 6, p. 255; am. 2001, ch. 155, § 3, p. 558; am. 2005, ch. 268, § 1, p. 829; am. 2014, ch. 89, § 1, p. 239.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 89, added paragraph (2)(g).

41-3616. Credits for assessments paid. — (1) A member insurer may offset against its premium tax liability to this state under section 41-402,

Idaho Code, an assessment described in subsection (1)(d) of section 41-3608, Idaho Code. An offset is allowable to the extent of twenty percent (20%) of the amount of such assessment for each of five (5) calendar years beginning with the premium tax due under section 41-402(4), Idaho Code, with respect to the year of payment of the assessment and thereafter with the premium tax due under section 41-402(4), Idaho Code, during each of the four (4) succeeding years. An allowable offset, or portion thereof, not used in any calendar year cannot be carried over or back to any other year. An insurer that is exempt from the premium tax imposed by section 41-402, Idaho Code, may offset against its premium tax liability to the industrial administration fund in the same manner as an offset to the premium tax imposed by section 41-402(4).

(2) Notwithstanding any provision to the contrary in section 41-3608(2)(f), Idaho Code, any sums acquired by refund from insurance company receiverships by the association which have heretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and which, in the opinion of the board of directors, will not be needed for the purposes of this chapter within two (2) years from the date the association receives the refund from the receivership, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the state general fund.

History.
1970, ch. 152, § 16, p. 462; am. 2004, ch. 241, § 1, p. 704; am. 2005, ch. 268, § 2, p. 829; am. 2013, ch. 265, § 1, p. 650.

STATUTORY NOTES

Cross References.
State treasurer, § 67-1201 et seq.

Amendments.
The 2013 amendment, by ch. 265, rewrote subsection (1) to the extent that a detailed comparison is impracticable.

CHAPTER 38

ACQUISITIONS OF CONTROL AND INSURANCE HOLDING COMPANY SYSTEMS

SECTION.

41-3801. Purpose. — The purpose of this chapter is to prevent acquisition or divestiture of control of an insurer or a holding company system of which an insurer is a part where such acquisition would be adverse to the public interest and the interests of policyholders and shareholders. A further purpose of this chapter is to promote the public interest and the interests of policyholders and shareholders by facilitating, consistent with those interests, better use of management skills and services, diversification through acquisitions, free access to capital markets, sound tax planning and open competition. An additional purpose is to monitor and regulate insurance holding company systems.

History.
I.C., § 41-3801, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former chapter 38 of Title 41, which comprised the following sections, was repealed by S.L. 2013, ch. 266, § 1, effective July 1, 2013.

41-3801. Definitions. [I.C., § 41-3801, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 15, p. 492.]

41-3801A. Purpose. [I.C., § 41-3801A, as added by 1981, ch. 214, § 1, p. 382.]

41-3801B. Subsidiaries of insurers. [I.C., § 41-3801B, as added by 1993, ch. 194, § 16, p. 492.]

41-3802. Acquisition of control of a domestic insurer. [I.C., § 41-3802, as added by 1981, ch. 214, § 3, p. 382; am. 1982, ch. 266, § 1, p. 686; am. 1990, ch. 213, § 59, p. 480; am. 1993, ch. 194, § 17, p. 492.]

41-3803. Tender offer material. [I.C., § 41-3803, as added by 1972, ch. 163, § 1, p. 365.]

41-3805. Approval, disapproval of proposed acquisition. [I.C., § 41-3805, as added by 1972, ch. 163, § 1, p. 365; am. 1981, ch. 214, § 4, p. 382; am. 1982, ch. 266, § 2, p. 686; am. 1990, ch. 375, § 1, p. 1037; am. 1993, ch. 194, § 19, p. 492; am. 1998, ch. 303, § 3, p. 997.]

41-3805A. Mailing — Payment of expenses. [I.C., § 41-3805A, as added by 1981, ch. 214, § 5, p. 382; am. 1982, ch. 266, § 3, p. 686.]

41-3805B. Acquisitions involving insurers not otherwise covered. [I.C., § 41-3805B, as added by 1993, ch. 194, § 20, p. 492.]

41-3806. Registration of holding company system insurers. [I.C., § 41-3806, as added by 1972, ch. 163, § 1, p. 365; am. 1981, ch. 214, § 6, p. 382; am. 1993, ch. 194, § 21, p. 492; am. 1996, ch. 305, § 3, p. 1000; am. 1999, ch. 65, § 8, p. 168.]

41-3807. Transactions with affiliates — Standards. [I.C., § 41-3807, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 22, p. 492.]

41-3808. Insurers surplus — Adequacy factors. [I.C., § 41-3808, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 23, p. 492.]

41-3809. Dividends and distributions. [I.C., § 41-3809, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 24, p. 492.]

41-3810. Verification of information. [I.C., § 41-3810, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 25, p. 492.]

41-3811. Communications. [I.C., § 41-3811, as added by 1972, ch. 163, § 1, p. 365; am. 1990, ch. 213, § 60, p. 480.]

41-3813. Rules and regulations. [I.C., § 41-3813, as added by 1972, ch. 163, § 1, p. 365.]

41-3814. Supplemental to existing provisions. [I.C., § 41-3814, as added by 1993, ch. 194, § 28, p. 492.]

41-3815. Injunctions. [I.C., § 41-3815, as added by 1981, ch. 214, § 7, p. 382; am. 1993, ch. 194, § 29, p. 492.]

41-3816. Sanctions. [I.C., § 41-3816, as added by 1993, ch. 194, § 30, p. 492.]

41-3817. Receivership. [I.C., § 41-3817, as added by 1993, ch. 194, § 31, p. 492.]

41-3818. Recovery. [I.C., § 41-3818, as added by 1993, ch. 194, § 32, p. 492.]

41-3819. Revocation, suspension, or nonrenewal of insurer's license. [I.C., § 41-3819, as added by 1993, ch. 194, § 33, p. 492.]

41-3820. Judicial review, mandamus. [I.C., § 41-3820, as added by 1993, ch. 194, § 34, p. 492.]

41-3821. Mutual insurance holding companies. [I.C., § 41-3821, as added by 1998, ch. 303, § 1, p. 998; am. 2003, ch. 271, § 1, p. 722; am. 2004, ch. 30, § 1, p. 53; am. 2004, ch. 45, § 7, p. 169.]

41-3802. Definitions. — As used in this chapter the following terms shall have the following meanings:

(1) "Affiliate" of, or a person "affiliated" with, a specific person, means a person who directly or indirectly through one (1) or more intermediaries controls or is controlled by, or is under common control with, the person specified.

(2) "Control," including "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or a corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in section 41-3809(11), Idaho Code, that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Enterprise risk" means any activity, circumstance, event or series of events involving one (1) or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section 41-5403, Idaho Code, or would cause the insurer to be in hazardous financial condition as set forth by rule in IDAPA 18.01.66.

(4) "Insurance holding company system" means two (2) or more affiliated persons, one (1) or more of whom is an insurer.

(5) "Insurer" has the same meaning as that set forth in section 41-103, Idaho Code, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision of a state.

(6) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a business trust, an unincorporated organization, or any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

(7) "Security holder" means a person who owns any security of a specified person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

(8) "Subsidiary" means a specified person who is an affiliate controlled by such person directly or indirectly through one (1) or more intermediaries.

(9) "Voting security" means any security convertible into or evidencing a right to acquire a voting security.

History.
I.C., § 41-3802, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3802 was repealed. See Prior Laws, § 41-3801.
Another former § 41-3802, which comprised I.C., § 41-3802, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1981, ch. 214, § 2, effective April 6, 1981.

41-3803. Subsidiaries of insurers. — (1) A domestic insurer, either by itself or in cooperation with one (1) or more persons, may organize or acquire one (1) or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

(2) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under title 41, Idaho Code, a domestic insurer may also:

(a) Invest in common stock, preferred stock, debt obligations and other securities of one (1) or more subsidiaries in amounts that do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus regarding policyholders, provided that after making such investments, the insurer's surplus regarding policyholders will be reasonable in relation to the insurer's outstanding liabilities and will be adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded, but the following shall be included:

(i) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(ii) All amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation.

(b) Invest any amount in common stock, preferred stock, debt obligations and other securities of one (1) or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided that each subsidiary agrees to limit its investment in any asset so that the investment will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph (a) of this subsection or in chapter 7, title 41, Idaho Code, applicable to the insurer. For the purpose of this section, "the total investment of the insurer" shall include:

(i) Any direct investment by the insurer in an asset; and

(ii) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary.

(c) With the approval of the director, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one (1) or more subsidiaries, provided that after making the investment, the insurer's surplus regarding policyholders will be reasonable in relation to the insurer's outstanding liabilities and will be adequate to its financial needs.

(3) Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (2)(a) of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in title 41, Idaho Code, applicable to such investments of insurers.

(4) Whether any investment made pursuant to subsection (2) of this section meets the applicable requirements thereof is to be determined before the investment is made by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(5) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the director may prescribe, unless at any time after the investment shall have been made the investment shall have met the requirements for investment under any other section of title 41, Idaho Code, and the insurer has so notified the director.

History.
I.C., § 41-3803, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3803 was repealed. See Prior Laws, § 41-3801.

41-3804. Acquisition of control of controlling interest with domestic insurer — Acquisition of merger or divestiture of controlling interest with domestic insurer. — (1) The following filing requirements shall apply:

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consum-

mation thereof, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the director and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the director in the manner prescribed in this chapter.

(b) For purposes of this section, any controlling person of a domestic insurer seeking to divest his controlling interest of the domestic insurer, in any manner, shall file with the director, with a copy to the insurer, confidential notice of his proposed divestiture at least thirty (30) days prior to the cessation of control. The director shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the director, in his discretion, determines that confidential treatment will interfere with or impede enforcement of this section. If the statement referred to in paragraph (a) of this subsection is otherwise filed, this section shall not apply.

(c) With respect to a transaction subject to this section, the acquiring or divesting person must also file a preacquisition notification with the director that contains the information set forth in section 41-3808(3)(a), Idaho Code, at least thirty (30) days prior to the proposed effective date of the acquisition. A failure to timely file the notification may subject the acquiring or divesting person to penalties as specified in section 41-3808(5)(e), Idaho Code.

(d) For purposes of this section, a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the director, is either directly or through his affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person who controls an insurance company.

(2) The statement to be filed with the director as referenced in this section shall be made under oath or affirmation and shall contain the following:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) of this section is to be effected, hereinafter called the "acquiring party"; and

(i) If the person is an individual, his principal occupation and all offices and positions held during the past five (5) years and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(ii) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period

as the person and any predecessors shall have been in existence; a detailed description of the business intended to be conducted by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include, for each individual, the information required by paragraph (a)(i) of this subsection; and

(iii) For individuals who are directors or executive officers of an entity, the information from time to time that is specified by the director on the biographical affidavit form prescribed by the department of insurance;

(b) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration;

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party, or for such lesser period as the acquiring party and any predecessors shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(d) Any plans or proposals that each acquiring party may have to liquidate the insurer, to sell the insurer's assets or merge or consolidate the insurer with any person, or to make any other material change in the insurer's business or corporate structure or management;

(e) The number of shares of any security referred to in subsection (1) of this section that each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (1) of this section, and a statement as to the method by which the fairness of the proposal was determined;

(f) The amount of each class of any security referred to in subsection (1) of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (1) of this section in which any acquiring party is involved including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

(h) A description of the purchase of any security referred to in subsection (1) of this section during the twelve (12) calendar months preceding the filing of the statement required by this section by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(i) A description of any recommendations to purchase any security referred to in subsection (1) of this section made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) of this section, and if distributed, of additional solicitation material relating thereto;

(k) The term of any agreement, contract or understanding made with, or proposed to be made with, any broker-dealer as to solicitation of securities referred to in subsection (1) of this section for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

(*l*) An agreement by the person required to file the statement referenced in subsection (1) of this section that it will provide the annual report specified in section 41-3809(12), Idaho Code, for so long as its control exists;

(m) An acknowledgment by the person required to file the statement referenced in subsection (1) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the director upon request as necessary to evaluate enterprise risk to the insurer; and

(n) Such additional information as the director may prescribe by rule as necessary or appropriate for the protection of policyholders and security holders of the insurer or in the director's determination is in the public interest.

(3) If the person required to file the statement referenced in subsection (1) of this section is a partnership, limited partnership, syndicate or other group, the director may require that the information required by subsection (2)(a) through (n) of this section shall be provided to the director with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation, or the person required to file the statement referenced in subsection (1) of this section is a corporation, the director may require that the information required by subsection (2)(a) through (n) of this section shall be provided to the director with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

(4) If any material change occurs in the facts set forth in the statement filed with the director and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the director and sent to the insurer within two (2) business days after the person learns of the change.

(5) If any offer, request, invitation, agreement or acquisition referenced in subsection (1) of this section is proposed to be made by means of a

registration statement under the securities act of 1933, or in circumstances requiring the disclosure of similar information under the securities exchange act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) of this section may use the documents in furnishing the information required by that statement.

History.
I.C., § 41-3804, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
41-3804. Information as to tender offeror. [I.C., § 41-3804, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 18, effective July 1, 1993.]
Another former § 41-3804 was repealed. See Prior Laws, § 41-3801.

Federal References.
The securities act of 1933, referred to in subsection (5), is codified as 15 U.S.C.S. § 77a et seq.
The securities exchange act of 1934, referred to in subsection (5), is codified as 15 U.S.C.S. § 78a et seq.

41-3805. Tender offer material. — All requests or invitations for tenders or advertisements making a tender offer or requesting or inviting tenders of such voting securities for control of a domestic insurer made by or on behalf of any person shall contain the information specified in section 41-3804, Idaho Code, as the director may prescribe and shall be filed with the director at least ten (10) days prior to the time such material is first published or sent or provided to security holders. Copies of any additional material soliciting or requesting such tender offers subsequent to the initial solicitation or request shall contain information as the director may prescribe as necessary or appropriate in the public interest or for the protection of policyholders and stockholders and shall be filed with the director at least ten (10) days prior to the time copies of the material are first published or sent or provided to security holders.

History.
I.C., § 41-3805, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3805 was repealed. See Prior Laws, § 41-3801.

41-3806. Approval by director — Hearings. — (1) The director shall approve any purchase, exchange, merger or other acquisition of control referred to in section 41-3804(1), Idaho Code, or in section 41-3824, Idaho Code, unless, after a public hearing, the director finds that:

(a) After the change of control, the domestic insurer referenced in section 41-3804(1), Idaho Code, would be unable to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the purchase, exchange, merger or other acquisition of control would substantially lessen competition in the business of insurance in this state or tend to create a monopoly. In applying the competitive standard in this paragraph:

(i) The informational requirements of section 41-3808(3)(a), Idaho Code, and the standards of section 41-3808(4)(b), Idaho Code, shall apply;

(ii) The merger or other acquisition shall not be disapproved if the director finds that any of the situations meeting the criteria provided by section 41-3808(4)(c), Idaho Code, exist; and

(iii) The director may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(c) The financial condition of any acquiring party may jeopardize the financial stability of the insurer or prejudice the interest of its policyholders or, in the case of an acquisition of control, the interest of any remaining stockholders who are unaffiliated with the acquiring person;

(d) The plans or proposals of the acquiring party to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and are not in the public interest;

(e) The competence, experience and integrity of the persons who would control the operation of the insurer are such that it would not be in the interest of policyholders and stockholders of the insurer or of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referenced in subsection (1) of this section shall be held within thirty-five (35) days after the statement required by section 41-3804(1), Idaho Code, is filed or as otherwise agreed to by the director and the person filing the statement, and at least twenty-one (21) days' notice of such hearing shall be given by the director to the person filing the statement. Not less than seven (7) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the director. All discovery proceedings to the extent agreed to by the parties or allowed by the director shall be concluded not later than three (3) business days prior to the commencement of the public hearing. The director shall make a determination within fifty-six (56) days after conclusion of such hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and shall be entitled to conduct discovery proceedings in the same manner as allowed under chapter 2, title 41, Idaho Code, and applicable rules.

(3) If the proposed acquisition of control will require the approval of more than one (1) commissioner, the public hearing referenced in subsection (2) of

this section may be held on a consolidated basis, upon written request to all affected commissioners by the person filing the statement referenced in section 41-3804(1), Idaho Code. Such person shall file the statement referenced in section 41-3804(1), Idaho Code, with the national association of insurance commissioners within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt-out within fourteen (14) days of the receipt of the statement referenced in section 41-3804(1), Idaho Code. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the affected insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the director that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to section 41-3804(1)(a) of this chapter. Failure of the director to provide a determination within the prescribed time shall not negate the application of capital requirements otherwise required by title 41, Idaho Code, but may affect the time within which such requirements must be met.

(5) The director may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the director's staff as may be reasonably necessary to assist the director in reviewing the proposed acquisition of control. The director may require the acquiring party to post a bond in an amount not to exceed twenty-five thousand dollars ($25,000) as security for payment of such expenses.

(6) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition that the director by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not anticipated by this section.

(7) The following shall be violations of this section:

(a) The failure to file any statement, amendment or other material required to be filed pursuant to the provisions of section 41-3804(1) or (2), Idaho Code; or

(b) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with a domestic insurer unless the director has given prior approval.

(8) The district courts of the state of Idaho are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the director under the provisions of section 41-3804, Idaho Code, and over all actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the director to be his true and lawful attorney

upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the director and transmitted by registered or certified mail by the director to the person at his last known address.

History.
I.C., § 41-3806, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3806 was repealed. See Prior Laws, § 41-3801.

41-3807. Mailing — Payment of expenses. — (1) All notices of public hearings held pursuant to section 41-3806, Idaho Code, shall be mailed by the insurer to its shareholders within five (5) business days after the insurer has received such notices. The expenses of such mailing shall be borne by the person making the filing. As security for the payment of such expenses, such person shall file with the director a bond or other deposit deemed acceptable and in an amount determined by the director.

(2) The provisions of this section shall not apply to any offers, requests, invitations, agreements or acquisitions by the person referred to in section 41-3804, Idaho Code, of any voting security referred to in section 41-3804, Idaho Code, which, immediately prior to the consummation of such offer, request, invitation, agreement or acquisition, was not issued and outstanding.

History.
I.C., § 41-3807, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3807 was repealed. See Prior Laws, § 41-3801.

41-3808. Acquisitions involving insurers not otherwise covered. — (1) The following definitions shall apply for the purposes of this section only:

(a) "Acquisition" means any agreement, arrangement or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers;

(b) "Involved insurer" means an insurer that either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

(2) This section applies to any acquisition in which there is a change in

control of an insurer authorized to do business in this state. This section shall not apply to the following:

(a) An acquisition subject to approval or disapproval by the director pursuant to sections 41-3804 and 41-3806, Idaho Code;

(b) A purchase of securities solely for investment purposes, so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under the provisions of section 41-3802(2), Idaho Code, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist, and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the director;

(c) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the director in accordance with subsection (3)(a) of this section thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subsection of this section;

(d) The acquisition of already affiliated persons;

(e) An acquisition if, as an immediate result of the acquisition:

(i) In no market would the combined market share of the involved insurers exceeds five percent (5%) of the total market;

(ii) There would be no increase in any market share; or

(iii) In no market would:

1. The combined market share of the involved insurers exceeds twelve percent (12%) of the total market; and

2. The market share increases by more than two percent (2%) of the total market.

For the purpose of paragraph (e) of this subsection, a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(f) An acquisition for which a preacquisition notification would be required pursuant to the provisions of this section due solely to the resulting effect on the ocean marine insurance line of business; or

(g) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the director.

(3) An acquisition covered by subsection (2) of this section may be subject to the issuance of an order pursuant to subsection (5) of this section, unless the acquiring person files a preacquisition notification and the waiting

period has expired. The acquired person may file a preacquisition notification with the director. The director shall give confidential treatment to information submitted under the provisions of this subsection in the same manner as provided in section 41-3816, Idaho Code.

(a) The preacquisition notification shall be in such form and contain such information as prescribed by the director relating to those markets which, under subsection (2)(e) of this section, cause the acquisition not to be exempted from the provisions of this section. The director may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (4) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his ability to render an informed opinion.

(b) The waiting period required shall begin on the date of receipt by the director of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of receipt or termination of the waiting period by the director. Prior to the end of the waiting period, the director may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the director or termination of the waiting period by the director.

(4)(a) The director may enter an order under subsection (5)(a) of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly, or if the insurer fails to file adequate information in compliance with subsection (3) of this section.

(b) In determining whether a proposed acquisition would violate the competitive standard of paragraph (a) of this subsection, the director shall consider the following:

(i) Any acquisition covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standards.

1. If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

2. Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two (2) columns in the table is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection. For the purpose of this determination, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection if:

1. There is a significant trend toward increased concentration in the market;

2. One (1) of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

3. Another involved insurer's market is two percent (2%) or more.

(iii) For the purposes of paragraph (b) of this subsection:

1. "Insurer" means any company or group of companies under common management, ownership or control;

2. "Market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the director shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the national association of insurance commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, which line is that used in the annual statement required to be filed by insurers doing business in this state and the relevant geographical market is assumed to be this state;

3. The burden of showing prima facie evidence of violation of the competitive standard rests upon the director.

(iv) Even if an acquisition is not prima facie violative of the competitive standard under subsection (4)(b)(i) and (ii) of this section, the director may establish the requisite anticompetitive effect based upon other substantial evidence. Even if an acquisition is prima facie violative of the competitive standard under subsection (4)(b)(i) and (ii) of this section, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant

factors in making a determination under this subsection include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(c) An order may not be entered under subsection (5)(a) of this section if:

(i) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits that would arise from such economies exceed the public benefits that would arise from not lessening competition; or

(ii) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits that would arise from not lessening competition.

(5)(a) If an acquisition violates the provisions of this section, the director may enter an order:

(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(ii) Denying the application of an acquired or acquiring insurer for a certificate of authority to do business in this state.

(b) Such an order shall not be entered unless:

(i) A hearing has been held in accordance with chapter 2, title 41, Idaho Code;

(ii) Notice of the hearing was issued prior to the end of the waiting period and not less than fourteen (14) days prior to the hearing; and

(iii) The hearing was concluded and the order issued no later than fifty-six (56) days after the date of the filing of the preacquisition notification with the director.

Every order shall be accompanied by a written decision of the director setting forth findings of fact and conclusions of law.

(c) An order entered under the provisions of this subsection shall not become final earlier than twenty-eight (28) days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon such plan or other information, the director shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the provisions of this section would be remedied and the order vacated or modified.

(d) An order pursuant to this section shall not apply if the acquisition is not consummated.

(e) Any person who violates a cease and desist order of the director issued pursuant to subsection (5)(a) of this section and while the order is in effect may, after notice and the opportunity for a hearing and upon order of the director, be subject at the discretion of the director to one (1) or more of the following:

(i) A monetary penalty of not more than ten thousand dollars ($10,000) for every day of violation; and/or

(ii) Suspension or revocation of the person's certificate of authority in this state.

(f) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than fifty thousand dollars ($50,000).

(6) Sections 41-3818(2) and (3) and 41-3820, Idaho Code, do not apply to acquisitions covered under subsection (2) of this section.

History.
I.C., § 41-3808, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3808 was repealed. See Prior Laws, § 41-3801.

Compiler's Notes.
For more on the national association of insurance commissioners, see *http://naic.org*.

41-3809. Registration of holding company system insurers. — (1) Every insurer authorized to do business in this state and that is a member of an insurance holding company system shall register with the director, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile, which are substantially similar to those contained in this section and in:

(a) Sections 41-3810(1), 41-3811 and 41-3812, Idaho Code; and

(b) The provisions of section 41-3810(2), Idaho Code, or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer that is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter for the year ending December 31 immediately preceding, on the due date provided for filing of audited financial reports, or, if the insurer is not subject to filing of audited financial reports, on June 1, unless the director, for good cause shown, extends the time for registration, and then within the extended time. The director may require any insurer authorized to do business in the state that is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in subsection (3) of this section or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction. Upon request of the insurer or of the insurance regulatory authority of another jurisdiction in which the insurer is authorized to transact insurance, the director at the insurer's expense shall furnish a copy of the registration statement or other information filed by a domestic insurer with the director pursuant to this chapter.

(2) Every insurer subject to registration under this chapter shall file the registration statement with the director on a form and in a manner prescribed by the director. The registration statement shall contain the following current information:

(a) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(b) The identity and relationship of every member of the insurance holding company system;

(c) The following agreements in force and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

(i) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) Purchases, sales or exchange of assets;

(iii) Transactions not in the ordinary course of business;

(iv) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) All management agreements, service contracts and all cost-sharing arrangements;

(vi) Reinsurance agreements;

(vii) Dividends and other distributions to shareholders; and

(viii) Consolidated tax allocation agreements.

(d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the director, the insurer shall provide to the director financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the U.S. securities and exchange commission (SEC) pursuant to the securities act of 1933, as amended, or the securities exchange act of 1934, as amended. An insurer required to file financial statements pursuant to this section may satisfy the request by providing the director with the most recently filed parent corporation financial statements that have been filed with the SEC;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the director;

(g) Certification that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures; and

(h) Any other information required by the director by statute or rule.

(3) All registration statements shall contain a summary outlining all items constituting changes from the prior registration statement.

(4) No information need be disclosed on the registration statement filed pursuant to subsection (2) of this section if the information is not material for the purposes of this section. Unless the director by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, invest-

ments or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of the December 31 of the year immediately preceding shall not be deemed material for purposes of this chapter.

(5) Subject to section 41-3810, Idaho Code, each registered insurer shall report to the director all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

(6) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(7) The director shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system.

(8) The director may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.

(9) The director may allow any insurer that is authorized to do business in this state and that is part of an insurance holding company system, to register on behalf of any affiliated insurer that is required to register under subsection (1) of this section and to comply with all filing requirements under this chapter.

(10) The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the director by rule or order shall exempt the same from the provisions of this section. In considering whether to issue an exemption, the director may consider the following:

(a) The size of the insurer and all affiliates;

(b) The structure of ownership within the insurance holding company system;

(c) The nature and amounts of transactions within the insurance holding company system;

(d) The nature and complexity of the business of the insurer and affiliates; and

(e) Any other factors the director deems appropriate.

Prior to issuing an exemption, the director shall notify all other insurance regulators where the insurer or its affiliates hold a certificate of authority.

(11) Any person may file with the director a disclaimer of affiliation with any authorized insurer, or such a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the director, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing pursuant to chapter 2, title 41, Idaho Code, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the director, or if the disclaimer is deemed to have been approved.

(12) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state director of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the national association of insurance commissioners.

(13) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required in this section within the time specified for filing shall be a violation of the provisions of this section.

History.
I.C., § 41-3809, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3809 was repealed. See Prior Laws, § 41-3801.

Federal References.
The securities act of 1933, referred to in paragraph (2)(e), is codified as 15 U.S.C.S. § 77a et seq.

The securities exchange act of 1934, referred to in paragraph (2)(e), is codified as 15 U.S.C.S. § 78a et seq.

For more on securities and exchange commission, see *http://www.sec.gov*.

Compiler's Notes.
The abbreviations enclosed in parentheses so appeared in the law as enacted.

41-3810. Standards and management of an insurer within an insurance holding company system. — (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost-sharing services and management shall include such provisions as required by rule promulgated by the director;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(f) The insurer's surplus regarding policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this

section, that are subject to any materiality standards contained in paragraphs (a) through (g) of this subsection, may not be entered into unless the insurer has notified the director in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the director may permit, and the director has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported to the director within thirty (30) days after the termination of a previously filed agreement, for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, guarantees or investments, provided the transactions are equal to or exceed:

(i) With respect to non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus regarding policyholders as of December 31 of the year immediately preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of December 31 of the year immediately preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed:

(i) With respect to non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus regarding policyholders as of December 31 of the year immediately preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of December 31 of the year immediately preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities, in any of the next three (3) years, equals or exceeds five percent (5%) of the insurer's surplus regarding policyholders, as of December 31 of the year immediately preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and the nonaffiliate that any portion of the assets will be transferred to one (1) or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer, provided however, that a guarantee that is quantifiable as to amount is not subject to the notice requirement of this section, unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of

surplus regarding policyholders as of December 31 of the year immediately preceding. Further, all guarantees that are not quantifiable as to amount are subject to the notice requirements of this section;

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with the insurer's present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to section 41-3803, Idaho Code, or authorized under any other section of this chapter, or in nonsubsidiary insurance affiliates that are subject to the provisions of this chapter, are exempt from this requirement; and

(g) Any material transactions, specified by statute or rule, that the director determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section shall be deemed to authorize or permit any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the director determines that separate transactions were entered into over any twelve (12) month period for that purpose, the director may exercise his authority pursuant to section 41-3819, Idaho Code.

(4) The director, in reviewing transactions pursuant to subsection (2) of this section, shall consider whether the transactions comply with the standards set forth in subsection (1) of this section and whether they may adversely affect the interests of policyholders.

(5) The director shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation, if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

History.
I.C., § 41-3810, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3810 was repealed. See Prior Laws, § 41-3801.

41-3811. Adequacy of surplus. — For purposes of this chapter, in determining whether an insurer's surplus regarding policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus,

reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's investment portfolio;

(8) The surplus regarding policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves;

(10) The quality and liquidity of investments in affiliates; the director may treat any investment in an affiliate as a disallowed asset for purposes of determining the adequacy of surplus regarding policyholders whenever in the judgment of the director the investment so warrants; and

(11) The quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items.

History.
I.C., § 41-3811, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3811 was repealed. See Prior Laws, § 41-3801.

41-3812. Dividends and other distributions. — (1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the director has received notice of the declaration thereof and has not within that period disapproved the payment, or until the director has approved the payment within the thirty (30) day period. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(a) Ten percent (10%) of the insurer's surplus regarding policyholders as of December 31 of the year immediately preceding; or

(b) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve (12) month period ending December 31 of the year immediately preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an

insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carryforward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the director's approval, and the declaration shall confer no rights upon shareholders until the director has approved the payment of the dividend or distribution or until the director has not disapproved payment within the thirty (30) day period referred to in this subsection.

(2) A domestic insurer that is a member of a holding company system shall notify the director in writing of any nonextraordinary dividends to be paid or other distributions to be made to shareholders within five (5) business days following the declaration of the dividend or distribution, and shall notify the director in writing at least ten (10) days, commencing from the date of receipt by the director, prior to the payment of any dividends or the making of any other distribution.

History.
I.C., § 41-3812, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
41-3812. Jurisdiction of courts. [I.C., § 41-3812, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 26, effective July 1, 1993.]

Another former § 41-3812 was repealed. See Prior Laws, § 41-3801.

41-3813. Management of domestic insurers subject to registration. — (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one (1) or more other persons under arrangements meeting the standards of section 41-3810(1), Idaho Code.

(3) Not less than one-third (1/3) of the directors of a domestic insurer, and not less than one-third (1/3) of the members of each committee of the board of directors of any domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one (1) person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one (1) or more committees comprised solely of directors who are not officers or

employees of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of subsections (3) and (4) of this section shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of subsections (3) and (4) of this section with respect to such controlling entity.

(6) An insurer may make application to the director for a waiver from the requirements of this section, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the federal crop insurance corporation and national flood insurance program, is less than three hundred million dollars ($300,000,000). An insurer may also make application to the director for a waiver from the requirements of this section based upon unique circumstances. The director may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members or the ownership or organizational structure of the entity.

History.
I.C., § 41-3813, as added by 2013, ch. 266, § 2, p. 652; am. 2014, ch. 97, § 27, p. 265.

STATUTORY NOTES

Prior Laws.
Former § 41-3813 was repealed. See Prior Laws, § 41-3801.

Amendments.
The 2014 amendment, by ch. 97, substituted "national flood insurance program" for "federal flood program" in the first sentence in subsection (6).

Compiler's Notes.
For more on federal crop insurance corporation, see *http://www.rma.usda.gov/fcic*.

For further information on the national flood insurance program, see *http://www.fema.gov/national-flood-insurance-program*.

41-3814. Examination. — (1) Power of director. Subject to the limitation contained in this section and in addition to the authority the director has under chapter 2, title 41, Idaho Code, relating to the examination of insurers, the director shall have the power to examine any insurer registered under section 41-3809, Idaho Code, and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(2) The director may order any insurer registered under section 41-3809, Idaho Code, to produce such records, books or other information in the

possession or control of the insurer or its affiliates as are reasonably necessary to determine compliance with this chapter. For such purpose, the director may order any insurer registered under section 41-3809, Idaho Code, to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations or other method. In the event the insurer cannot obtain the information requested by the director, the insurer shall provide the director with a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the director that the detailed explanation is without merit, the director may require, after notice and the opportunity for a hearing, that the insurer pay a penalty in the amount and in the manner provided in section 41-3819(1), Idaho Code, and may suspend or revoke the insurer's license.

(3) The director may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the director's staff as shall be reasonably necessary to assist in the conduct of the examination referenced in subsection (1) of this section. Persons so retained shall be under the direction and control of the director for the purposes stated herein and shall act in a purely advisory capacity.

(4) Each registered insurer producing for examination records, books and papers pursuant to subsection (1) of this section shall be liable for and shall pay the expense of examination in accordance with the provisions of section 41-228, Idaho Code, and applicable rules promulgated by the director.

(5) In the event the insurer fails to comply with an order issued by the director, the director shall have the power to examine the insurer's affiliates to obtain the information. The director shall also have the power to issue subpoenas, to administer oaths and to examine under oath any person for purposes of determining compliance with the provisions of this section. Upon the failure or refusal of any person to obey a subpoena issued by the director, the director may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obligated to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He shall be entitled to the same fees and mileage, if claimed, as a witness in the district court, which fees, mileage and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against and be paid by the company being examined.

History.
I.C., § 41-3814, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3814, which comprised I.C., § 41-3814, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 27,

effective July 1, 1993.
Another former § 41-3814 was repealed.
See Prior Laws, § 41-3801.

41-3815. Supervisory colleges. — (1) With respect to any insurer registered under section 41-3809, Idaho Code, and in accordance with subsection (3) of this section, the director is authorized to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this chapter. The powers of the director with respect to supervisory colleges include, but are not limited to, the following:

(a) Initiating the establishment of a supervisory college;

(b) Clarifying the membership and participation of other supervisors in the supervisory college;

(c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities and processes for information sharing; and

(e) Establishing a crisis management plan.

(2) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates and the director may establish a regular assessment to the insurer for the payment of these expenses.

(3) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with section 41-3813, Idaho Code, the director may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The director may enter into agreements in accordance with section 41-3816(3), Idaho Code, providing the basis for cooperation among the director and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the director to regulate or supervise the insurer or its affiliates within its jurisdiction.

History.
I.C., § 41-3815, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3815 was repealed. See Prior Laws, § 41-3801.

41-3816. Confidential treatment. — (1) Documents, materials or other information in the possession or control of the department that are obtained by or disclosed to the director or any other person in the course of an examination or investigation made pursuant to section 41-3814, Idaho Code, and all information reported pursuant to sections 41-3804(2), 41-3809 and 41-3810, Idaho Code, shall be confidential by law and privileged, shall be exempt from public disclosure, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains, unless the director, after giving the insurer and its affiliates who would be affected notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication, in which event the director may publish all or any part in such manner as may be deemed appropriate.

(2) Neither the director nor any person who receives documents, materials or other information while acting under the authority of the director or with whom such documents, materials or other information is shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's duties under title 41, Idaho Code, the director:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, including members of any supervisory college described in section 41-3815, Idaho Code, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information and has verified in writing the legal authority to maintain confidentiality.

(b) Notwithstanding the provisions of subsection (3)(a) of this section, the director may only share confidential and privileged documents, materials or information reported pursuant to section 41-3809(12), Idaho Code, with commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information.

(c) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the

national association of insurance commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(d) Shall enter into written agreements with the national association of insurance commissioners governing sharing and use of information provided pursuant to the provisions of this chapter consistent with this subsection, which agreements shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the national association of insurance commissioners with other state, federal or international regulators;

(ii) Specify that ownership of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter remains with the director, and the national association of insurance commissioners' use of the information is subject to the direction of the director;

(iii) Require prompt notice to be given to an insurer whose confidential information is in the possession of the national association of insurance commissioners pursuant to this chapter that disclosure of such confidential information has been requested or subpoenaed or otherwise sought; and

(iv) Require the national association of insurance commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial, administrative or similar action in which the national association of insurance commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the national association of insurance commissioners and the insurer's affiliates and subsidiaries pursuant to this chapter.

(4) The sharing of information by the director pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director under the provisions of this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials or other information in the possession or control of the national association of insurance commissioners pursuant to this chapter shall be confidential and privileged, shall not be a public record, shall not be subject to public disclosure, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.

History.
I.C., § 41-3816, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3816 was repealed. See Prior Laws, § 41-3801.

Compiler's Notes.
For more on the national association of insurance commissioners, see *http://naic.org*.

41-3817. Rules. — The director may promulgate rules and issue orders as shall be necessary to carry out the provisions of this chapter.

History.
I.C., § 41-3817, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3817 was repealed. See Prior Laws, § 41-3801.

41-3818. Injunctions, prohibitions against voting securities, sequestration of voting securities. — (1) Whenever it appears to the director that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of the provisions of this chapter or of any rule or order issued by the director hereunder, the director may apply to the district court, fourth judicial district for Ada county, for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate the provisions of this chapter or any rule or order thereunder, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

(2) No security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of the provisions of this chapter or of any rule or order issued by the director hereunder, may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; however, no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this state so order. If an insurer or the director has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule or order issued by the director hereunder, the insurer or the director may apply to the fourth judicial district court for Ada county to enjoin any offer, request, invitation, agreement or acquisition made in contravention of section 41-3804, Idaho Code, or any rule or order issued by the director to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders, and for such other equitable relief as the nature of

the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

(3) In any case where a person has acquired or is proposing to acquire any voting securities in violation of the provisions of this chapter or any rule or order issued by the director hereunder, the fourth judicial district court for Ada county, on such notice as the court deems appropriate, upon the application of the insurer or the director, shall seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this chapter.

(4) Notwithstanding any other provisions of law, for the purposes of this chapter, the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History.
I.C., § 41-3818, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3818 was repealed. See Prior Laws, § 41-3801.

41-3819. Sanctions. — (1) Any insurer failing, without just cause, to file any registration statement as required in this chapter shall be required, after notice and the opportunity for a hearing, to pay a penalty of two hundred dollars ($200) for each day of delay, to be recovered by the director, and the penalty so received shall be distributed to the general fund of the state of Idaho. The maximum penalty under this section is ten thousand dollars ($10,000). The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) Every director or officer of an insurance holding company system who knowingly violates, participates in or assents to, or who knowingly permits any of the officers or agents of the insurer to engage in transactions or make investments that have not been properly reported or submitted pursuant to section 41-3809(1), 41-3810(2) or 41-3812, Idaho Code, or who violates the provisions of this chapter shall pay, in their individual capacity, an administrative penalty of not more than five thousand dollars ($5,000) per violation, after notice and the opportunity for a hearing before the director. In determining the amount of the administrative penalty, the director shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of any previous violations and such other matters as the interests of justice may require.

(3) Whenever it appears to the director that any insurer subject to this chapter or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract that is subject to section 41-3810 or 41-3812, Idaho Code, and that would not have been approved had approval been requested, the director may order the insurer to cease and desist immediately from any further activity under that transaction or

contract. After notice and the opportunity for a hearing, the director may also order the insurer to void any contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

(4) Whenever it appears to the director that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this chapter, the director may seek criminal proceedings to be instituted by referring the matter to the attorney general or the county prosecutor in the county in which the principal office of the insurer is located, or if the insurer has no office in this state, then in Ada county, Idaho, against the insurer or the responsible director, officer, employee or agent thereof. Any insurer who willfully violates the provisions of this chapter may be fined not more than five thousand dollars ($5,000). Any individual who willfully violates the provisions of this chapter shall be guilty of a felony and may be imprisoned for not more than two (2) years or fined in his individual capacity not more than five thousand dollars ($5,000), or both.

(5) Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the director in the performance of his duties under the provisions of this chapter, upon conviction shall be imprisoned for not more than three (3) years or fined five thousand dollars ($5,000), or both. Any fines imposed shall be paid by the officer, director or employee in his individual capacity.

(6) Whenever it appears to the director that any person has committed a violation of the provisions of section 41-3804, Idaho Code, and which prevents the director from fully understanding the enterprise risk to the insurer by affiliates or by the insurance holding company system, such violation may serve as an independent basis for the director's disapproval of dividends or distributions and for placing the insurer under an order of supervision in accordance with chapter 33, title 41, Idaho Code.

History.
I.C., § 41-3819, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3819 was repealed. See Prior Laws, § 41-3801.

41-3820. Receivership. — Whenever it appears to the director that any person has committed a violation of the provisions of this chapter that so impairs the financial condition of a domestic insurer as to threaten insolvency or make its further transaction of business hazardous to its policyholders, creditors, shareholders or the public, the director may proceed as provided in chapter 33, title 41, Idaho Code, to take possession of the property of the domestic insurer and to conduct its business in the capacity of a receiver.

History.
I.C., § 41-3820, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3820 was repealed. See Prior Laws, § 41-3801.

41-3821. Recovery. — (1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall be authorized to recover on behalf of the insurer:

(a) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock; or

(b) Any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to this subsection is made at any time during the one (1) year period preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (2), (3) and (4) of this section.

(2) No distribution shall be recoverable if the parent or affiliate of such domestic insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under subsection (1) of this section, that the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable pursuant to this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due pursuant to subsection (3) of this section, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

History.
I.C., § 41-3821, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.
Former § 41-3821 was repealed. See Prior Laws, § 41-3801.

41-3822. Revocation, suspension or nonrenewal of insurer's license. — Whenever it appears to the director that any person has committed a violation of the provisions of this chapter that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the director may, after giving notice and the opportunity for a hearing, suspend, revoke or refuse to renew the insurer's license or certificate of authority to do business in this state for such period as the director finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

History.
I.C., § 41-3822, as added by 2013, ch. 266, § 2, p. 652.

41-3823. Judicial review — Mandamus. — (1) Any person aggrieved by any act, determination, rule or order or any other action of the director pursuant to this chapter may appeal to the fourth judicial district court for Ada county, Idaho. The court shall conduct its review in accordance with the provisions of chapter 52, title 67, Idaho Code, or other applicable provisions of law.

(2) The filing of an appeal pursuant to this section shall stay the application of any rule, order or other action of the director to the party pursuing such appeal, unless the court, after providing the party with notice and the opportunity for a hearing, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

(3) Any person aggrieved by any failure of the director to act or make a determination required by this chapter may petition the fourth judicial district court for Ada county for a writ in the nature of a mandamus or a peremptory mandamus directing the director to act or make a determination.

History.
I.C., § 41-3823, as added by 2013, ch. 266, § 2, p. 652.

41-3824. Mutual insurance holding companies. —
(1)(a) A domestic mutual insurer, upon approval of the director, may reorganize by forming an insurance holding company system, which shall be designated as "a mutual insurance holding company," based upon a mutual insurance company plan and continuing the corporate existence of

the reorganizing insurer as a stock insurer. The director, after a public hearing as provided in section 41-3806, Idaho Code, if satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, may approve the proposed plan of reorganization and may require as a condition of approval such modifications of the proposed plan of reorganization as the director finds necessary for the protection of the policyholders' interests. The director may retain consultants for this purpose as provided in section 41-3806(5), Idaho Code. A reorganization pursuant to this section is subject to the requirements of sections 41-3804 and 41-3805, Idaho Code. The director shall retain jurisdiction over a mutual insurance holding company organized pursuant to this section to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurer shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurer.

(2)(a) A domestic mutual insurer, upon the approval of the director, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to subsection (1) of this section and continuing the corporate existence of the reorganizing insurer as a stock insurer subsidiary of the mutual insurance holding company. The director, after a public hearing as provided in section 41-3806, Idaho Code, if satisfied that the interests of the policyholders are properly protected and that the merger is fair and equitable to the policyholders, may approve the proposed merger and may require as a condition of approval such modifications of the proposed merger as the director finds necessary for the protection of the policyholders' interests. For this purpose, the director may retain consultants as provided in section 41-3806(5), Idaho Code. A merger pursuant to this subsection is subject to sections 41-3804 and 41-3805, Idaho Code. The director shall retain jurisdiction over the mutual insurance holding company organized pursuant to this section to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurer shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurer. A merger of

policyholders' membership interests in a mutual insurer into a mutual insurance holding company shall be deemed to be a merger of insurance companies pursuant to section 41-2857, Idaho Code, and is subject to the requirements of section 41-2857, Idaho Code.

(c) A foreign mutual insurer that is a domestic insurer organized under chapter 3, title 41, Idaho Code, may reorganize upon the approval of the director and in compliance with the requirements of any law or rule applicable to the foreign mutual insurer by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to subsection (1) of this section and continuing the corporate existence of the reorganizing foreign mutual insurer as a foreign stock insurer subsidiary of the mutual insurance holding company. The director, after a public hearing as provided in section 41-3806, Idaho Code, may approve the proposed merger. The director may retain consultants as provided in section 41-3806(5), Idaho Code. A merger pursuant to this paragraph is subject to the requirements of sections 41-3804 and 41-3805, Idaho Code. The reorganizing foreign mutual insurer may remain a foreign company or foreign corporation after the merger and may be admitted to do business in this state, upon approval by the director. A foreign mutual insurer that is a party to the merger may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile. The provisions of subsection (2)(b) of this section shall apply to a merger authorized under this paragraph.

(3) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurer organized under chapter 1, title 30, Idaho Code, shall be incorporated pursuant to chapter 1, title 30, Idaho Code. This requirement shall supersede any conflicting provisions of chapter 1, title 30, Idaho Code. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the director in the same manner as those of an insurance company.

(4) A mutual insurance holding company is deemed to be an insurer subject to chapter 33, title 41, Idaho Code, and shall automatically be a party to any proceeding under chapter 33, title 41, Idaho Code, involving an insurer that, as a result of a reorganization pursuant to subsection (1) or (2) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding under chapter 33, title 41, Idaho Code, involving the reorganized insurer, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurer for purposes of satisfying the claims of the reorganized insurer's policyholders. A mutual insurance holding company shall not be dissolved or liquidated without the prior approval of the director or as ordered by the district court pursuant to chapter 33, title 41, Idaho Code.

(5)(a) Section 41-2855, Idaho Code, is not applicable to a reorganization or merger pursuant to this section.

(b) Section 41-2855, Idaho Code, is applicable to demutualization of a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurer organized pursuant to chapter 3, title 41, Idaho Code, as if the domestic mutual insurer were a mutual life insurer.

(6) A membership interest in a domestic mutual insurance holding company shall not constitute a security as defined in section 30-14-102(28), Idaho Code.

(7) The majority of the voting shares of the capital stock of the reorganized insurer, which is required by this section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subject to a security interest or lien, encumbered or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation or alienation of, in or on the majority of the voting shares of the reorganized insurer that is required by this section to be at all times owned by a mutual insurance holding company, is in violation of the provisions of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurer that is required by this section to be at all times owned by a mutual insurance holding company shall not be subject to execution and levy as provided in title 11, Idaho Code. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two (2) or more reorganized insurers or two (2) or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions and limitations as provided in this section to which the shares of the merging or consolidating reorganized insurers or intermediate holding companies were subject as provided in this section prior to the merger or consolidation.

(a) As used in this section, "majority of the voting shares of the capital stock of the reorganized insurer" means shares of the capital stock of the reorganized insurer that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurer for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurer. The ownership of a majority of the voting shares of the capital stock of the reorganized insurer that is required pursuant to this section to be at all times owned by a parent mutual insurance holding company includes indirect ownership through one (1) or more intermediate holding companies in a corporate structure approved by the director. However, indirect ownership through one (1) or more intermediate holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurer. The director shall have jurisdiction over an intermediate holding company as if it were a mutual insurance holding company.

(b) As used in this section, "intermediate holding company" means a holding company that is a subsidiary of a mutual insurance holding company and that either directly or through a subsidiary intermediate holding company has one (1) or more subsidiary-reorganized insurers of

which a majority of the voting shares of the capital stock would otherwise have been required pursuant to this section to be at all times owned by the mutual insurance holding company.

(8) It is the intent of the legislature that the formation of a mutual insurance holding company shall not increase the Idaho tax burden of the mutual insurance holding company system and that a stock insurance subsidiary shall continue to be subject to Idaho insurance premium taxation in lieu of all other taxes except real property taxes as provided in section 41-405, Idaho Code. Subject to approval by the director as required under Idaho law, a stock insurance subsidiary may issue dividends or distributions to the mutual insurance holding company or any intermediate holding company and such dividends or distributions shall be excluded from the Idaho taxable income of the recipients; provided however, that such exclusion shall not apply if, in the year preceding the year in which the dividends or distributions were made, the subsidiary insurer's liability for Idaho premium tax was less than the amount of Idaho income tax, computed after allowance for income tax credits, for which the insurer would have been liable in such year had the insurer been subject to Idaho income taxation rather than premium taxation.

History.
I.C., § 41-3824, as added by 2013, ch. 266, § 2, p. 652.

41-3825. Severability. — The provisions of this chapter are hereby declared to be severable and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this chapter.

History.
I.C., § 41-3825, as added by 2013, ch. 266, § 2, p. 652.

CHAPTER 40

SELF-FUNDED HEALTH CARE PLANS

SECTION.

41-4001. Declaration of purpose. — (1) The purpose of this chapter is to recognize and provide reasonable supervision of self-funded or partially self-funded plans for provision of health care service benefits to employees or to students of a postsecondary educational institution in connection with or as an alternative to insurance and other prepayment plans, to provide standards for financial soundness of such plans, to protect the interests of employees or students covered thereby and to provide for the establishment of financially viable alternatives to traditional health care plans. The legislature of the state of Idaho declares that the existence and operation of such self-funded plans are matters of legislative concern, vitally affecting the rights and interests of the citizens of this state.

(2) The provisions of this chapter shall apply to any single employer or multiple employer plan or any postsecondary educational institution that provides a fully or partially self-funded health benefit plan for beneficiaries residing in this state to the extent that state regulation of such plan is not preempted by the employee retirement income security act of 1974, as amended.

History.
1974, ch. 248, § 1, p. 1624; am. 2006, ch. 414, § 1, p. 1257; am. 2013, ch. 181, § 1, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, inserted "or to students of a postsecondary educational institution," "or students," and "the establishment of" in the first sentence in subsection (1) and inserted "plan or any postsecondary educational institution that provides a" in subsection (2).

Federal References.
The employee retirement income security act of 1974, referred to in subsection (2), is compiled throughout Title 26 of the United States Code.

41-4002. Definitions. — For the purposes of this chapter unless context otherwise requires:

(1) "Administrator" is a person, if other than the trustee, employed or contracted by the trustee to provide administrative services to a self-funded plan.

(2) "Beneficiary" is any individual entitled, under the self-funded plan, to payment by the trust fund of any part or all of the cost of any health care service rendered to such beneficiary.

(3) "Claims liability" is the total of all incurred and unpaid claims, including incurred but not reported claims, for allowable benefits under a self-funded plan that are not reimbursed or reimbursable by stop-loss insurance provided by a carrier authorized to transact insurance in this state.

(4) "Contribution" is the amount paid or payable by the employer or employee, or a postsecondary educational institution or student, into the trust fund.

(5) "Department" is the Idaho department of insurance.

(6) "Director" is the director of the department of insurance.

(7) "Irrevocable trust agreement" is a trust agreement whereby under the

terms thereof the plan sponsor cannot retain the power to alter, amend, revoke or terminate the transfer of funds or property held in trust.

(8) "Multiple employer welfare arrangement" or "multiple employer welfare plan" shall have the same meaning as that given to the term "multiple employer welfare arrangement" by the employee retirement income security act of 1974, as amended.

(9) "Person" is any individual, corporation, limited liability company, partnership, association, firm, syndicate, organization, educational institution or any other public or private entity organized or recognized under the laws of the state of Idaho.

(10) "Plan sponsor" is any person who creates a self-funded health benefit plan for the benefit of any employer and employee or employees, or a postsecondary educational institution and student or students.

(11) "Postsecondary educational institution" is a person whose primary purpose is to provide a postsecondary education that offers or awards educational degrees and that provides courses or programs that lead to an educational degree, that is legally authorized and maintains a presence in the state of Idaho, and that has an average annualized enrollment of eight hundred (800) or more full-time students located in Idaho.

(12) "Qualified actuary" is an actuary having experience in establishing rates for a self-funded plan and the health services being provided, and who is also a fellow of the society of actuaries, a member of the American academy of actuaries or an enrolled actuary under the employee retirement income security act of 1974, as amended.

(13) "Self-funded plan" or "plan" is any single employer plan or multiple employer welfare plan, or any other single or multiple employer plan, or any postsecondary educational institution student health benefit plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by contributions or payments thereto by the employer or employers, or by the employer or employers and the employees, or by a postsecondary educational institution and students at said institution, or students of a postsecondary educational institution, who are not otherwise covered by insurance or contract with a health care service corporation or managed care organization authorized to transact business in this state.

(14) "Single employer" is any individual, sole proprietorship, business, partnership, corporation, limited liability company, firm or any other form of legally recognized entity or a group of two (2) or more employers under "common control" as defined in section 3(40)(B)(iii) of the employee retirement income security act of 1974, as amended.

(15) "Student" is an individual enrolled in a postsecondary educational institution.

(16) "Surplus" is the excess of the assets of a self-funded plan minus the liabilities of the plan, provided the liabilities of a self-funded plan shall include the claims liability of the plan.

(17) "Trust fund" is a trust fund established in conjunction with a self-funded plan for receipt of contributions of employer and employees, postsecondary educational institution and students, and payment of or with respect to health care service costs of beneficiaries.

(18) "Trustee" is the trustee, whether a single or multiple trustee, of the trust fund.

History.
1974, ch. 248, § 2, p. 1624; am. 2006, ch. 414, § 2, p. 1257; am. 2013, ch. 181, § 2, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, added the definitions of department, irrevocable trust agreement, postsecondary education institution, qualified actuary, and student and their subsection designations; deleted "or 'reserves'" following "'Claims liability'" in subsection (3); added "multiple employer welfare plan" to subsection (8); rewrote subsection (9) which read "'Person' is any individual, corporation, association, firm, syndicate, organization, or other entity"; inserted language relating to postsecondary educational institution and students throughout the section; and substituted "retirement income security act" for "retirement system act" in subsection (14).

Federal References.
The employee retirement income security act of 1974, referred to in subsections (8) and (12), is compiled throughout Title 26 of the United States Code.

"Multiple employer welfare arrangement" is defined for that act in 29 USCS § 1002(40).

"Common control" is defined for that act in 29 USCS § 1002(40)(B)(iii).

41-4003. Registration required — Exemptions — Not subject to insurance code. — (1) No person shall offer or operate a self-funded plan in this state unless the plan is registered with the director as hereinafter provided.

(2) No registration shall be required of:

(a) Any self-funded plan established for the sole purpose of funding the dollar amount of a deductible clause contained in the provisions of an insurance contract issued by an insurer duly authorized to transact disability insurance in this state if the deductible does not exceed an amount applicable to each beneficiary of five thousand dollars ($5,000) per annum and the total of all obligations to all beneficiaries insured under the plan arising out of the application of such a deductible does not exceed the aggregate amount of five hundred thousand dollars ($500,000) in any one (1) year.

(b) Any plan established and maintained for the purpose of complying with any worker's compensation law or unemployment compensation disability insurance law.

(c) Any plan administered by or for the federal government or agency thereof or any county of this state.

(d) Any plan which is primarily for the purpose of providing first aid care and treatment by an employer for injury or sickness of employees while engaged in their employment.

(e) Any self-funded plan offering only dental and/or vision benefits, where such benefits are limited to no more than a total of five thousand dollars ($5,000) per beneficiary per year. If self-funded dental and/or vision benefits are offered in conjunction with any other self-funded plan for

disability or health benefits, the entire benefits are subject to all applicable provisions of chapter 40, title 41, Idaho Code, including registration.

(3) Plans that are registered under chapter 40, title 41, Idaho Code, shall not be deemed to be engaged in the business of insurance and shall not be subject to provisions of the Idaho insurance code except as expressly provided in this chapter. A plan required to register with the department that operates in this state without registering under this chapter shall be deemed to be engaged in the business of insurance without authorization and any person offering or operating an unregistered plan shall be deemed to be transacting insurance without proper licensing and subject to all sanctions as provided by law.

(4) Any self-funded plan providing benefits to more than one (1) employer shall provide to each employer participant and to each prospective employer participant written notice that the plan is not insurance and does not participate in the Idaho life and health guaranty association. Any self-funded plan providing benefits to students of a postsecondary educational institution shall provide to each student participant and to each prospective student participant written notice that the plan is not insurance and does not participate in the Idaho life and health guaranty association. The notice shall also be included as part of all marketing materials used by or on behalf of the plan.

(5) Any plan registered as a single employer plan or as a multiple employer welfare plan shall not operate as or be registered as a postsecondary educational institution student health benefit plan. Any plan registered as a postsecondary educational institution student health benefit plan shall not operate as or be registered as a single employer plan or as a multiple employer welfare plan.

History.

1974, ch. 248, § 3, p. 1624; am. 2001, ch. 308, § 1, p. 1114; am. 2004, ch. 86, § 1, p. 321; am. 2006, ch. 414, § 3, p. 1257; am. 2013, ch. 181, § 3, p. 419.

STATUTORY NOTES

Cross References.

Idaho life and health guaranty association, § 41-4301 et seq.

Amendments.

The 2013 amendment, by ch. 181, in paragraph (2)(a), substituted "five thousand dollars ($5,000)" for "two thousand dollars ($2,000)" and "five hundred thousand dollars ($500,000)" for "two hundred thousand dollars ($200,000)"; added paragraph (2)(e); in subsection (3), inserted "under chapter 40, title 41, Idaho Code," in the first sentence and "required to register with the department," "without authorization," and "and subject to all sanctions as provided by law" in the last sentence; inserted the second sentence in subsection (4); and added subsection (5).

41-4004. Plan requirements. — (1) The director shall not register any self-funded plan under this chapter unless the following requirements are met:

(a) The plan must require all contributions to be paid in advance and to be deposited in and disbursed from a trust fund duly created by a written irrevocable trust agreement between the employer or employers and the

trustee, or between the postsecondary educational institution and the trustee, that meets the terms of this chapter.

(b) The plan shall appoint a trustee who demonstrates the character, fitness and competence to function in such role and whose function shall be to competently manage and administer the trust fund and plan.

(c) With regard to single employer plans or multiple employer welfare plans, the plans must require that employers contribute to the trust fund, and that all contributions by employees, if any, shall be by regular periodic payroll deductions, except as to contributions made by an employee during his absence from such employment for such period as the plan may reasonably provide.

(d) The plan must provide that the trustee shall furnish to each employee-beneficiary or each student-beneficiary a copy of the plan, which shall include a written statement or schedule adequately and clearly stating all benefits currently provided under the plan, as well as all applicable restrictions, limitations, and exclusions, and the procedure for filing a claim for benefits.

(e) The plan shall require that the trust fund be actuarially sound. Assets and income of the trust fund shall at all times be reasonably adequate to provide for full payment of all benefits promised to beneficiaries by the plan and to cover all other costs of operation. The initial contribution rates shall be calculated by a qualified actuary and shall include a reasonable provision for adverse deviation and a reasonable contribution to surplus.

(f) Before the registration by the department of the self-funded plan, the department shall verify that an amount equal to fifty percent (50%) of the qualified actuary's estimate of the minimum surplus requirements, as provided in section 41-4010(3), Idaho Code, after twelve (12) months of operation be deposited in the trust fund, in addition to the first month's contributions for all beneficiaries.

(2) After registration of the plan, in addition to the required quarterly and annual filings and other requirements as provided in this chapter, the trustee shall file the following documents with the director for his review and approval not less than thirty (30) days before the effective date thereof:

(a) An actuarial study as described in section 41-4005(2)(e), Idaho Code, calculating new rates for the next plan year or more frequent period if there are any midterm rate changes;

(b) Any changes in the policy form, benefits or summary plan description;

(c) Any amendments or changes made to the stop-loss agreement or agreements, including change of carriers;

(d) Any amendments or changes made to administrative, service or management agreements;

(e) Any amendments or changes to the fidelity bond or other coverage the director deemed equivalent pursuant to section 41-4014(3), Idaho Code;

(f) Any amendments or changes to the trust agreement; and

(g) Any change in the trustee or trustees, officers or management of the trust, which notice shall include biographical affidavits of any new trustee, officer or management personnel.

(3) The trustee shall notify the director immediately if the trustee learns

or receives information that indicates that the surplus of the trust falls below the minimum surplus requirements.

History.
1974, ch. 248, § 4, p. 1624; am. 1990, ch. 169, § 1, p. 366; am. 2006, ch. 414, § 4, p. 1257; am. 2013, ch. 181, § 4, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote the section, adding paragraph (1)(f) and subsections (2) and (3).

41-4005. Application for registration — Fee. — (1) Application for registration of a self-funded plan shall be made to the director, on forms prescribed by the director, seeking such information concerning whether, in the opinion of the director, the plan is qualified for registration. The application shall require the applicant to designate whether the plan is applying for registration as a single employer plan or multiple employer welfare plan or as a postsecondary educational institution student health benefit plan. The application shall be signed and verified by at least one (1) employer or, if applicable, by a person authorized by a postsecondary educational institution to sign the application and at least one (1) plan trustee. If the employer, postsecondary educational institution, or trustee is a corporation, the verification shall be by a duly authorized corporate officer or by a managing member of the plan sponsor if the plan sponsor is a limited liability company.

(2) The application shall be accompanied by all plan documents including:

(a) A copy of the irrevocable trust agreement under which the trust fund is to exist and operate;

(b) A copy of the proposed written statement of benefits referenced in section 41-4004(1)(d), Idaho Code;

(c) A financial statement of the trust fund, if already in existence and operating at the time of application, certified by an independent certified public accountant. If the trust fund is not in existence at the time of application, a pro forma balance sheet for the start of operation of the plan and a pro forma balance sheet, by month, for the first twelve (12) months of operation of the plan shall accompany the application, provided that all balance sheets shall include actuarially determined claims liabilities;

(d) A written statement of reasonably projected income and disbursements of the trust fund, by month, for the twelve (12) month period commencing with the effective date of registration of the trust with the department and including changes to claims liabilities fully set forth in the monthly expenses as calculated by a qualified actuary;

(e) A copy of an actuarial study prepared by a qualified actuary certifying that the rates for the plan are sufficient to cover moderately adverse experience and all costs of operation. The study shall include the development and justification of the assumptions used by the actuary in determining the rates. The rates shall not be less than the sum of projected incurred claims for the year, plus costs of operation, plus any

prior year deficiency, less any excess surplus prior to the establishment of the contribution deficit reserve;

(f) With regard to a single employer plan or a multiple employer welfare plan, if the plan is domiciled outside this state, a letter or other written evidence of good standing from the plan's regulator in the state of domicile;

(g) A copy of every contract between the plan and any administrator, trustee or service company;

(h) A copy of a stop-loss insurance agreement issued by an insurer authorized to do business in this state providing both specific and aggregate coverage in an amount as annually indicated in the actuarial opinion for the plan, provided the director may waive the requirements for aggregate stop-loss coverage if such coverage is not reasonably available or otherwise deemed appropriate;

(i) A copy of the policy, contract, certificate, summary plan description or other evidence of the benefits and coverages provided to beneficiaries, including a table of the rates charged or proposed to be charged for each form of such contract accompanied by a certification of a qualified actuary that:

(i) The rates are neither inadequate nor excessive nor unfairly discriminatory;

(ii) The rates are appropriate for the classes of risks for which they have been computed; and

(iii) An adequate description of the rating methodology has been filed with the director and the methodology follows consistent and equitable actuarial principles; and

(j) Such other relevant documentation and information as the director may reasonably require.

(3) The application shall be signed under oath by the plan sponsor or the trustee of the plan, and the application shall also include:

(a) A copy of any articles of incorporation and bylaws or any founding documents and bylaws of any entity acting as a plan sponsor;

(b) A list of the names, addresses and official capacities concerning the plan of the individuals who will be responsible for the management and conduct of the affairs of the plan, including all trustees, officers and directors. Biographical affidavits shall be submitted for all trustees and management personnel on a form prescribed by the director. Management personnel of the trust shall be experienced and competent to ensure the trust's compliance with Idaho laws and rules. Such individuals shall fully disclose the extent and nature of any contracts or arrangements between them and the plan, including any possible conflicts of interest; and

(c) A copy of the articles of incorporation, bylaws, if any, and irrevocable trust agreement of the plan, as well as any other document concerning the operation of the plan.

(4) At the time of filing the application the applicant shall pay to the director a nonrefundable filing fee as provided for by rule.

(5) The director shall transmit and account for all fees received by him hereunder as provided in section 41-406, Idaho Code.

History.
1974, ch. 248, § 5, p. 1624; am. 1979, ch. 122, § 8, p. 375; am. 1984, ch. 23, § 12, p. 38; am. 2006, ch. 414, § 5, p. 1257; am. 2013, ch. 181, § 5, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote the section, deleting former subsection (6), relating to qualified actuaries.

41-4006. Grant or denial of registration. — (1) The director shall act upon an application for registration of a self-funded plan with all reasonable promptness, but not more than ninety (90) days from the date of submission of a complete application to the director. Failure to act within the ninety (90) day time period shall be deemed as registration of such self-funded plan by the director.

(2) The director may make such investigation of the application for registration as he deems advisable. If the director finds that the application is complete and that the plan meets the qualifications stated in sections 41-4004 and 41-4005, Idaho Code, and is otherwise consistent with the provisions of this chapter, he shall issue and deliver a certificate of registration in appropriate form to the applicant.

(3) In the event the director denies an applicant's application for registration, the director shall notify the applicant in writing of the basis for the denial. Within twenty-one (21) days of the issuance of the notice of denial, the applicant may submit to the director a written request for a hearing before the director or his duly appointed representative addressing the basis for the denial of the application and requesting that the director reexamine the applicant's qualifications for registration. An applicant's failure to request a hearing in writing within twenty-one (21) days of the issuance of the notice of denial shall be deemed a waiver of the opportunity for hearing.

History.
1974, ch. 248, § 6, p. 1624; am. 2006, ch. 414, § 6, p. 1257; am. 2013, ch. 181, § 6, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, added the subsection designations; substituted "not more than ninety (90) days" for "not less than (90) days" in subsection (1); in subsection (2), added the section reference, "41-4005" and added "and is otherwise consistent with the provisions of this chapter"; added a subsection (3), which rewrote language which was formerly compiled at the end of present subsections (1) and (2).

41-4007. Trust fund — Authority. — The trust fund of a self-funded plan shall have the authority:

(1) To have and use an appropriate descriptive name;

(2) To sue and be sued in its own name;

(3) To contract in its own name. All such contracts shall be in writing and shall be signed by the trustee of the fund, and if there is more than one (1) trustee, the contract may be so executed by one (1) trustee if so authorized by all trustees;

(4) To borrow money and give security therefor; and

(5) To engage exclusively in transactions authorized or required by this chapter, or reasonably incidental thereto.

History.
1974, ch. 248, § 7, p. 1624; am. 2006, ch. 414, § 7, p. 1257; am. 2013, ch. 181, § 7, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, substituted "Authority" for "Powers" in the section heading and "the authority" for "power" in the introductory paragraph.

41-4008. Trust fund liability — Fiduciary funds. — (1) The trust fund of a self-funded plan shall be legally liable for payment of all applicable benefits stated in the schedule of benefits for such plan in effect at the time a claim thereunder arises.

(2) Funds in the trust fund are fiduciary funds, and are not liable to any obligation of any plan sponsor, including any employer participant or postsecondary educational institution, nor are fiduciary funds held in the trust subject to garnishment or levy. The prohibition on garnishment or levy shall not be deemed to prohibit levy upon the trust fund by any provider thereof (or its assignee) for health care services rendered to a beneficiary.

(3) All funds and moneys received by the self-funded plan and all funds billed and paid as contributions to the trust fund shall be timely deposited in the trust account and shall be held in no other name than the name of the self-funded plan.

History.
1974, ch. 248, § 8, p. 1624; am. 2013, ch. 181, § 8, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, added "Fiduciary funds" in the section heading; rewrote subsection (2), which formerly read: "Funds in the trust fund are fiduciary funds, and are not liable for any obligation of any employer participant in the plan, nor subject to garnishment or levy for the obligation of any beneficiary. This clause shall not be deemed to prohibit levy upon the trust fund by any provider thereof (or its assignee) for health care services rendered a beneficiary if the trust fund has theretofore agreed in writing to pay for the same direct to such provider"; and added subsection (3).

Compiler's Notes.
The words in parentheses so appeared in the law as enacted.

41-4009. Investment of trust fund. — (1) The trustee may invest trust funds available for that purpose in the following kinds of investments only:

(a) General obligations of the United States government, or of any state, district, commonwealth, or territory of the United States, or of any municipality, county, or other political subdivision or agency thereof.

(b) Obligations, including the payment of principal and interest thereon of which are guaranteed by any such government or agency.

(c) Corporate bonds and similar obligations meeting the requirements

specified for investment of funds of insurers under section 41-711, Idaho Code.

(d) Collateral loans, including payment of principal and interest of which are adequately secured by securities in which the trust fund could lawfully invest directly.

(e) Deposits, savings accounts, and share accounts in chartered banks and savings and loan associations located in the United States. An investment in any one (1) such institution may not be in excess of the amount covered by applicable deposit, savings, and share account insurance, unless otherwise authorized by the director.

(f) Investments as permitted by sections 41-714 and 41-716, Idaho Code, provided that the combined amount of such investments shall not exceed ten percent (10%) of the total assets of the trust fund.

(2) In addition to investments excluded under subsection (1) of this section, the trustee is expressly prohibited from investing trust fund moneys in:

(a) Any loan to or security of any plan sponsor including any employer or postsecondary educational institution participating in the plan, or to or of any trustee, officer, director, subsidiary or affiliate of any such plan sponsor, employer or postsecondary educational institution.

(b) The security of any person in which the trustee, administrator, or any consultant of the plan has a direct or indirect material pecuniary interest.

(c) Real property or loans thereon.

(d) Any personal loan.

(3) All such investments shall be made and held in the name of the trust fund, and the interest and yield thereon shall inure to the benefit of the trust fund.

(4) No investment shall be made by or on behalf of the trust fund unless authorized in writing by the trustee and included in the records of the trust fund.

(5) Any person who authorizes any investment of trust fund moneys in violation of this section shall, in addition to other penalties that may be applicable therefor, be liable for all loss suffered by the trust fund on account of the investment.

(6) No investment made in violation of this section shall constitute an "asset" in any determination of the financial condition of the trust fund.

History.

1974, ch. 248, § 9, p. 1624; am. 2006, ch. 414, § 8, p. 1257; am. 2013, ch. 181, § 9, p. 419.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 181, in subsection (2), rewrote (a), which formerly read: "Any loan to or security of any employer participating in the plan, or to or of any officer, director, subsidiary or affiliate of any such employer" and rewrote (d), which formerly read: "Any personal loan, other than a collateral loan referred to in subsection (1)(d) of this section, but subject to paragraphs (a) and (b) of this subsection (2)"; added "by or on behalf of the trust fund" in subsection (4); and made stylistic changes throughout.

41-4010. Reserves and surplus. — (1) The trustee of a self-funded plan shall establish and maintain in the trust fund the following reserves:

(a) A reserve in an amount as certified by a qualified actuary as being necessary for payment of claims liability. The reserve shall be reasonably adjusted on a quarterly basis in an amount as determined by a qualified actuary or other qualified person if authorized by the director.

(b) If, under the plan, periodic contributions to the trust fund have been paid in advance or are payable less frequently than monthly, there shall be a reserve for unearned contributions as computed pro rata on the basis of the unexpired portion of the period for which the contribution has been paid.

(c) If future claims payments plus future costs of operation are greater than future contributions plus current reserves, there shall be a reserve in an amount equal to future claims payments plus future costs of operation, less future contributions, less current reserves.

(2) In any determination of the financial condition of the trust fund, the claims reserve, reserve for unearned contributions and contribution deficiency reserve shall constitute liabilities.

(3) In addition to reserves required by this section, a self-funded plan shall establish and maintain in its trust fund surplus equal to at least:

(a) The equivalence of three (3) months of contributions for the current plan year; or

(b) One hundred ten percent (110%) of the difference between the total dollar aggregate stop-loss attachment point plus costs of operation and the total dollar expected contributions for the current plan year.

(4) A surplus note that has been approved by the director in a form and as defined in section 41-2841, Idaho Code, may be used to fund surplus and shall not be accounted as a liability.

(5) Up to one-third (1/3) of the surplus required by this section may be funded by a clean, irrevocable letter of credit, in a form acceptable to the director, issued in favor of the trust fund by a federally or state chartered bank having a branch office in Idaho. Such irrevocable letter of credit cannot be guaranteed by pledge of any of the plan assets. The funding cannot be in the form of prepaid contributions or other loan or associated with an offsetting liability.

(6) A newly formed plan with no prior operating history shall meet the minimum surplus requirements no later than twelve (12) months after the date of initial operation. For plans registered with the department and in existence on the effective date of this law, such plans shall have twenty-four (24) months from the effective date of this law in which to increase their surplus level to comply with the requirements of subsection (3) of this section.

(7) The trust fund shall maintain the minimum surplus requirements at all times throughout the year.

History.
1974, ch. 248, § 10, p. 1624; am. 2006, ch. 414, § 9, p. 1257; am. 2013, ch. 181, § 10, p. 419.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 181, rewrote this section, adding subsections (4), (6) and (7) and the last sentence in subsection (5).

41-4011. Records and accounts — Annual statement. — (1) The trustee of a self-funded plan shall cause full and accurate records and accounts to be entered and maintained during all times of the existence of the trust covering all financial transactions and affairs of the trust fund, which records and accounts shall be subject to review by the director. Any audit of the plan or trust shall be completed independently of any other entity.

(2) Within ninety (90) days after close of a fiscal year of the plan, the trustee shall prepare an annual statement in writing summarizing the financial transactions of the trust fund for such fiscal year and the financial condition of the trust at the end of such year in accordance with the requirements of this chapter and with generally accepted accounting principles. The statement shall be in a form acceptable to the director and include such information as prescribed by the director. The financial information included therein shall be certified by the accountant who audited such information. The trustee shall promptly deliver a copy of the statement to each employer or postsecondary educational institution participating in the plan and keep a copy thereof on file in the business office from which the plan is operated. Such statement shall be available for review by any beneficiary at all reasonable times for a period of not less than three (3) years from the date of the statement. If the plan is managed by a third party administrator, such statement shall be available at the administrative offices of the employer or employers or postsecondary educational institution.

(3) The plan's annual statement shall be accompanied by the certified actuarial opinion described in section 41-4010, Idaho Code. Such annual statement shall be prepared in accordance with actuarial standard of practice no. 28. The self-funded plan shall require that the qualified actuary retain the actuarial work papers until the department has filed an examination report of the plan covering the period of the actuarial opinion but no longer than seven (7) years from the date of such opinion.

(4) On or before expiration of such ninety (90) day period the trustee shall file an original of the annual statement and certified actuarial opinion with the director. The actuarial opinion shall be filed in a form prescribed by the director. The trustee shall pay a filing fee as provided for by rule. The director may grant a thirty (30) day extension of the time for filing the annual statement.

(5) The trustee shall also file quarterly supplemental unaudited financial reports and other periodic supplemental unaudited financial reports in a form and at the times prescribed by the director.

(6) The director shall transmit and account for all fees received by him hereunder as provided in section 41-406, Idaho Code.

(7) The annual and quarterly reports required under this section are public records and are available to the public, notwithstanding the exemptions from disclosure provided in chapter 3, title 9, Idaho Code.

History.
1974, ch. 248, § 11, p. 1624; am. 1984, ch. 23, § 13, p. 38; am. 2006, ch. 414, § 10, p. 1257; am. 2010, ch. 96, § 2, p. 182; am. 2013, ch. 181, § 11, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote the section, adding subsection (3) and redesignating the subsequent subsections.

Compiler's Notes.
For actuarial standard of practice no. 28, referred to in subsection (3), see *http://www.actuarialstandardsboard.org/pdf/asops/asop028=u s 168.pdf.*

41-4012. Taxes. — (1) Each self-funded plan required to be registered under this chapter is subject to the tax as provided in this section. Each registered self-funded plan, and each formerly registered plan with respect to beneficiaries in this state while so registered, shall simultaneously with the filing of its annual statement with the director, pay to the director a tax computed at the rate of four cents (4¢) per month per beneficiary covered by the plan during the fiscal year of the annual statement with respect to all beneficiaries working or resident in this state. Any plans operating in Idaho without proper registration shall be subject to back taxes for all years the plan was in operation plus all other sanctions authorized by law.

(2) All excise, privilege, franchise, income, license and similar taxes, licenses and fees are hereby preempted from imposition upon self-funded plans and on the intangible property of their trust funds; and no county, city, municipality, district, school district, or other political subdivision or agency of Idaho shall levy upon such plans or trust funds any such tax, license or fee additional to those set forth in this chapter.

(3) The tax imposed on self-funded plans in subsection (1) of this section, together with the fees imposed on such plans as set forth in this chapter, shall be in lieu of any and all income taxes and other excise taxes, licenses and fees payable to the state of Idaho. No self-funded plan shall be required to file any tax returns or comply with any provisions governing such income taxes and other excise taxes, licenses and fees payable to the state of Idaho.

(4) The director shall promptly remit all such tax payments received by him pursuant to this section to the state treasurer for credit to the state general fund.

History.
1974, ch. 248, § 12, p. 1624; am. 1982, ch. 252, § 3, p. 643; am. 2006, ch. 414, § 11, p. 1257; am. 2013, ch. 181, § 12, p. 419.

STATUTORY NOTES

Cross References.
State treasurer, § 67-1201 et seq.

Amendments.
The 2013 amendment, by ch. 181, rewrote this section, adding the last sentence in subsection (1).

41-4013. Examination of books, records and accounts. — (1) The books, records, accounts and affairs of a self-funded plan shall be subject to

examination by the director, by qualified examiners duly authorized by him in writing, at such times or intervals as the director deems appropriate. The purposes of the examination shall be to determine compliance of the plan with applicable laws, the plan's financial condition, the adequacy of the plan's trust fund, the treatment accorded by the plan to its beneficiaries and any other factors deemed materially relevant by the director to the plan's management and operation.

(2) The trustee shall promptly make the books, records and accounts of the plan and trust fund available to the department's examiner in Idaho and otherwise facilitate the examination.

(3) The examiner shall conduct the examination expeditiously, prepare the report of the examination in writing, and deliver a copy thereof to the trustee and the director as soon as practicable. The trustee shall have no longer than four (4) weeks after receipt of the report within which to recommend to the director such corrections or changes therein as the trustee may deem appropriate. After making such corrections or changes, if any, as he deems appropriate, the director shall file the report in his office as a document open to public inspection, and deliver to the trustee a copy of the report, including any modifications made to the examiner's original report as submitted to the director.

(4) At the direction of the director, the costs of the examination shall be borne by the trust fund of the plan, and shall be paid by the trustee in accordance with section 41-228, Idaho Code.

History.
1974, ch. 248, § 13, p. 1624; am. 2001, ch. 85, § 12, p. 211; am. 2006, ch. 414, § 12, p. 1257; am. 2013, ch. 181, § 13, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote this section, adding subsection (4).

41-4014. Trustees — Administrators — Bonding. — (1) Either an individual or a corporation or other legal entity may be a trustee of the trust fund. Any person acting as a trustee is a fiduciary acting on behalf of the beneficiaries of the plan and the trust fund in such capacity. An individual, firm, corporation or other legal entity may be an administrator of a plan.

(2) An employer participant in the plan shall be neither a trustee nor the administrator. A postsecondary educational institution as a plan sponsor of a self-funded plan shall be neither a trustee nor an administrator of such plan. However, this subsection shall not prohibit an individual who is otherwise an employee of such an employer or a postsecondary educational institution from being trustee or administrator.

(3) The trustee shall obtain a fidelity bond, or coverage deemed by the director to be equivalent to a fidelity bond, in the name of the self-funded plan, the purpose of which is to protect against acts of fraud and dishonesty by the plan's trustees, directors, officers and employees in connection with the trust fund or plan. Such bond shall be in an amount equal to the greater of ten percent (10%) of the contributions received by the plan or ten percent

(10%) of the benefits paid during the preceding calendar year. If the plan was not in operation during the preceding calendar year, the bond shall be in an amount equal to ten percent (10%) of the contributions projected to be received by the plan during its first year of operation. The amount of any bond required under this section shall be not less than twenty-five thousand dollars ($25,000) or more than five hundred thousand dollars ($500,000).

(4) Any administrator that is retained by a self-funded plan must be licensed and bonded as an administrator pursuant to chapter 9, title 41, Idaho Code.

History.
1974, ch. 248, § 14, p. 1624; am. 2006, ch. 414, § 13, p. 1257; am. 2013, ch. 181, § 14, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote this section, adding subsection (4).

41-4015. Prohibited pecuniary interests in plan management. — (1) No plan sponsor, trustee, administrator, or other person having responsibility for the management of a self-funded plan or the investment or other handling of trust funds shall:

(a) Receive directly or indirectly or have a pecuniary interest, either directly or indirectly, in any fee, commission, compensation, or emolument, other than salary or other similar compensation regularly fixed and authorized for services duly rendered to the plan, arising out of any transaction to which the trust fund is or may become a party.

(b) Receive compensation as a consultant to the plan while also acting as a trustee or administrator, or as an employee of either the trust fund or the plan.

(c) Have any direct or indirect material pecuniary interest in any loan or investment related to the trust fund.

(2) No consultant to the plan or trust fund shall directly or indirectly receive or have a pecuniary interest, either directly or indirectly, in any commission or other compensation arising out of any contract or transaction between the plan or trust fund and any insurer, health care service corporation, health maintenance organization or other provider of health care services or of drugs or other health care needs and supplies.

(3) The director may, after reasonable notice and the opportunity for a hearing, require removal of a trustee or prohibit the trustee from employing or retaining or continuing to employ or retain any person in the administration of the trust fund or plan, upon finding that continuation of the trustee or such employment or retention involves a conflict of interest or an interest with the potential to adversely affect plan beneficiaries.

History.
1974, ch. 248, § 15, p. 1624; am. 2006, ch. 414, § 14, p. 1257; am. 2013, ch. 181, § 15, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, inserted "plan sponsor" near the beginning of subsection (1); substituted "have a pecuniary interest, either directly or indirectly" for "be pecuniary interested" in paragraph (1)(a) and in subsection (2); in subsection (2); inserted "the opportunity for a" preceding "hearing"; and made stylistic changes.

41-4017. Recovery of depleted funds. — If after notice and the opportunity for a hearing the director finds that any self-funded plan trust fund has been depleted by reason of any wrongful or negligent act or omission of a trustee or any other person, he shall transmit a copy of his findings to the attorney general of this state, who may bring an action in the name of the people of this state, or intervene in any action brought by or on behalf of an employer or beneficiary, for the recovery of the amount of such depletion, for the benefit of the trust fund, and to impose any sanctions as authorized by law.

History.
1974, ch. 248, § 17, p. 1624; am. 2013, ch. 181, § 16, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, inserted "the opportunity for a" near the beginning and added "and to impose any sanctions as authorized by law" at the end.

41-4018. Termination of registration. — (1) The director shall terminate the registration of a self-funded plan upon written request of the trustee, or if he finds, after an inquiry or an examination, that the trust fund is insolvent. For the purposes of this chapter, "insolvent" means the plan is unable to pay its obligations when they are due or that its assets do not exceed its liabilities. As used in this chapter, "assets" means all investments held in the name of the trust as permitted by section 41-4009, Idaho Code.

(2) The director may terminate the registration of a plan for violation of this chapter, or failure of the trustee to timely file with the director the annual statement or actuarial opinion and timely pay the tax required under sections 41-4011 and 41-4012, Idaho Code, or if he finds, after an inquiry or an examination of the trust fund and the plan or notice from the trustee:

(a) That the plan no longer meets the qualifications required by sections 41-4004 and 41-4005, Idaho Code, and that such deficiency will not or cannot be remedied within a reasonable time;

(b) That there is a pattern of benefits promised by the plan that are not being fairly and promptly paid;

(c) That the cost of administering the plan is excessive in relation to the character and volume of service being rendered in the administration;

(d) That the trust fund has been subject to fraudulent, incompetent or dishonest practices on the part of the trustee, administrator, consultant, any participating employer, any postsecondary educational institution, beneficiaries or others; or

(e) That the trust fund does not meet the minimum surplus requirements under this chapter.

(3) The director shall terminate the plan's registration by his written order provided to the trustee last of record with the department and to each employer or postsecondary educational institution last of record with the department. Such order shall state the grounds upon which it is based and its effective date. The order shall be subject to judicial review in the same manner as applies to official orders of the director in general.

History.
1974, ch. 248, § 18, p. 1624; am. 2006, ch. 414, § 15, p. 1257; am. 2013, ch. 181, § 17, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote this section to the extent that a detailed comparison is impracticable.

41-4019. Liquidation of trust fund. — (1) Upon termination of registration of the plan, the trust fund of a self-funded plan shall be liquidated as soon as practicable.

(2) Liquidation of a solvent self-funded plan shall be conducted by its trustee under a plan of liquidation in writing filed with and approved by the director as fair and equitable to all persons having a pecuniary interest in the trust fund. Any balance remaining after payment or adequate provision for all claims and charges against the trust fund shall be disposed of in such manner as is provided for in the plan of liquidation. Unless the plan of liquidation provides that liability for all unpaid claims and obligations of the trust fund has been unconditionally assumed by other financially responsible person or persons and the third party contract has been submitted to the department for its review, the existence of surplus funds for such disposition shall not be determined prior to expiration of two (2) years after termination of the registration.

(3) The liquidation of an insolvent self-funded plan shall be carried out by the director in accordance with chapter 33, title 41, Idaho Code (rehabilitation and liquidation). For this purpose, the self-funded plan shall be deemed to be an insolvent domestic insurer and subject to all statutes and rules applicable to the same.

History.
1974, ch. 248, § 19, p. 1624; am. 2006, ch. 414, § 16, p. 1257; am. 2013, ch. 181, § 18, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, rewrote this section to the extent that a detailed comparison is impracticable.

Compiler's Notes.
The words in parentheses so appeared in the law as enacted.

41-4020. Rules. — (1) The director may promulgate reasonable rules necessary for or as an aid to effectuation of any provision of this chapter. No

such rule shall extend, modify, or conflict with any provision of this chapter and the reasonable implications thereof.

(2) Such rules, or any amendment thereof, shall be made by the director in accordance with chapter 52, title 67, Idaho Code.

History.
1974, ch. 248, § 20, p. 1624; am. 2006, ch. 414, § 17, p. 1257; am. 2013, ch. 181, § 19, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, substituted "promulgate reasonable rules" for "make reasonable rules."

41-4021. Other provisions applicable. — Chapter 2, title 41, Idaho Code, (the director of the department of insurance), chapter 9, title 41, Idaho Code, (insurance administrators), chapter 13, title 41, Idaho Code, (trade practices and frauds), chapter 56, title 41, Idaho Code, (prompt payment of claims), chapter 59, title 41, Idaho Code, (external review), section 41-1845, Idaho Code, (recreational-related activities), sections 41-2141 and 41-2216, Idaho Code, (coordination with social security benefits), and section 41-2841, Idaho Code, (borrowed surplus), to the extent applicable and not in conflict with the express provisions of this chapter, shall also apply with respect to self-funded plans, and for the purpose such plans shall be deemed to be "insurers."

History.
1974, ch. 248, § 21, p. 1624; am. 1978, ch. 10, § 6, p. 19; am. 2006, ch. 414, § 18, p. 1257; am. 2013, ch. 181, § 20, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, inserted "chapter 9, title 41, Idaho Code, (insurance administrators)" and "chapter 56, title 41, Idaho Code, (prompt payment of claims), chapter 59, title 41, Idaho Code, (external review), section 41-1845, Idaho Code, (recreational-related activities)."

Compiler's Notes.
The words in parentheses so appeared in the law as enacted.

41-4022. Penalties. — (1) Any person who violates or causes or induces violation of any provision of this chapter, or any lawful rule of the director issued thereunder, shall be subject to an administrative penalty for each violation of not more than one thousand dollars ($1,000) for an individual and not more than five thousand dollars ($5,000) for any entity for each violation.

(2) Any person who makes a false statement or representation of a material fact, knowing it to be false, or who knowingly fails to disclose a material fact in any application, examination or statement relating to self-funded plans, trust accounts, administration of a plan or any matter materially related thereto, shall be subject to penalty as provided in subsection (4) of this section.

(3) Any person who makes a false entry in any book, record, statement, or report required by this chapter or any rule of the director promulgated thereunder, with intent to injure or defraud the trust fund or any beneficiary

thereunder, or to deceive anyone authorized or entitled to examine the affairs of the plan, shall be subject to penalty as provided in subsection (4) of this section.

(4) For each such violation, act or omission referred to in subsections (2) and (3) of this section, unless greater penalty is provided therefor under any other applicable law, the offender shall upon conviction thereof be subject to a fine of not more than fifteen thousand dollars ($15,000) and to imprisonment for not more than fifteen (15) years, or to both such fine and imprisonment.

(5) Further, the director may in his discretion:

(a) Order the person to cease and desist from the violation of such provision;

(b) Issue an order revoking or suspending the registration of the plan that engaged in such violation;

(c) Bring an action in the fourth district court in and for Ada county or in such other court as the director deems appropriate to seek appropriate injunctive relief and impose a civil penalty not to exceed five thousand dollars ($5,000) for each violation.

History.
1974, ch. 248, § 22, p. 1624; am. 2006, ch. 414, § 19, p. 1257; am. 2013, ch. 181, § 21, p. 419.

STATUTORY NOTES

Amendments.
The 2013 amendment, by ch. 181, in subsection (1) deleted "willfully" following "Any person who" at the beginning and added "for each violation" to the end; substituted "relating to self-funded plans, trust accounts, administration of a plan or any matter materially related thereto" for "required under this chapter or by lawful rule of the director thereunder" in subsection (2); added subsection (5); and made stylistic changes.

41-4023. Coverage from moment of birth — Complications of pregnancy. — (1) Every self-funded plan issued pursuant to this chapter in this state, or providing coverage to any covered family residing within this state, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal

finalization of adoption, the coverage required under the provisions of this subsection as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

(a) The date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the covered family rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn or adopted children or infants of a covered family, which child or children are covered from and after the moment of birth that is inconsistent with the provisions of this section.

(2) Neither the plan trustee or employer or a postsecondary educational institution nor an insurer shall restrict coverage under a self-funded plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) No self-funded plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan. This subsection shall apply to all self-funded plans except any such plan made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this subsection, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subsection and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no self-funded plan that provides maternity benefits shall restrict benefits for any hospital length of stay in

connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

(5) Any new or renewing self-funded group disability plan or blanket disability plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-six (26) years shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

History.

I.C., § 41-4023, as added by 1976, ch. 113, § 5, p. 443; am. 1993, ch. 305, § 5, p. 1129; am. 1994, ch. 365, § 10, p. 1144; am. 2006, ch. 414, § 20, p. 1257; am. 2008, ch. 296, § 4, p. 828; am. 2009, ch. 125, § 6, p. 391; am. 2013, ch. 181, § 22, p. 419.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 181, in subsection (1), inserted "pursuant to this chapter" near the beginning of the introductory paragraph and inserted "which child or children are" in the last paragraph; inserted "or a postsecondary educational institution" in subsection (2); and substituted "twenty-six (26) years" for "twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent" in subsection (5).

Federal References.

The Newborns' and Mothers' Health Protection Act of 1996, referred to in subsection (4) of this section, is compiled as 42 U.S.C.S., §§ 300gg-4, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-41 to 300gg-44, and 300gg-61 to 300gg-63.

CHAPTER 43

IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

SECTION.

41-4301. Short title. — This chapter shall be known and may be cited as the "Idaho Life and Health Insurance Guaranty Association Act."

History.

I.C., § 41-4301, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former chapter 43 of Title 41, which comprised the following sections, were repealed by S.L. 2011, ch. 196, § 1, effective July 1 2011.

41-4301. Short title. [I.C., § 41-4301, as added by 1977, ch. 217, § 1, p. 636.]

41-4302. Purpose. [I.C., § 41-4302, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 1, p. 617; am. 2000, ch. 371, § 3, p. 1224.]

41-4303. Application of chapter. [I.C., § 41-4303, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 1, p. 723; am. 2000, ch. 323, § 1, p. 1090; am. 2000, ch. 371, § 4, p. 1224; am. 2005, ch. 108, § 1, p. 356; am. 2009, ch. 54, § 1, p. 150.]

41-4304. Construction. [I.C., § 41-4304, as added by 1977, ch. 217, § 1, p. 636.]

41-4305. Definitions. [I.C., § 41-4305, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 2, p. 723; am. 2009, ch. 54, § 2, p. 150.]

41-4306. Creation of the association. [I.C., § 41-4306, as added by 1977, ch. 217, § 1, p. 636.]

41-4307. Board of directors. [I.C., § 41-4307, as added by 1977, ch. 217, § 1, p. 636.]

41-4308. Powers and duties of the association. [I.C., § 41-4308, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 2, p. 617; am. 2000, ch. 323, § 2, p. 1090; am. 2000, ch. 371, § 5, p. 1224; am. 2009, ch. 54, § 3, p. 150.]

41-4309. Assessments. [I.C., § 41-4309, as added by 1977, ch. 217, § 1, p. 636; am. 1986, ch. 43, § 1, p. 127; am. 2000, ch. 371, § 6, p. 1224; am. 2005, ch. 108, § 2, p. 356.]

41-4310. Plan of operation. [I.C., § 41-4310, as added by 1977, ch. 217, § 1, p. 636.]

41-4311. Duties and powers of the director. [I.C., § 41-4311, as added by 1977, ch. 217, § 1, p. 636.]

41-4312. Prevention of insolvencies. [I.C., § 41-4312, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 3, p. 617; am. 1990, ch. 213, § 61, p. 480.]

41-4313. Credits for assessments paid. [I.C., § 41-4313, as added by 1977, ch. 217, § 1, p. 636; am. 1994, ch. 239, § 1, p. 751.]

41-4314. Miscellaneous provisions. [I.C., § 41-4314, as added by 1977, ch. 217, § 1, p. 636.]

41-4315. Examination of the association — Annual report. [I.C., § 41-4315, as added by 1977, ch. 217, § 1, p. 636.]

41-4316. Tax exemptions. [I.C., § 41-4316, as added by 1977, ch. 217, § 1, p. 636.]

41-4317. Immunity. [I.C., § 41-4317, as added by 1977, ch. 217, § 1, p. 636.]

41-4318. Stay of proceedings — Reopening default judgments. [I.C., § 41-4318, as added by 1977, ch. 217, § 1, p. 636.]

41-4319. Prohibited advertisement of insurance guaranty association act in sale of insurance. [I.C., § 41-4319, as added by 1977, ch. 217, § 1, p. 636; am. 2009, ch. 54, § 4, p. 150.]

41-4302. Purpose. — (1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in section 41-4303(1), Idaho Code, against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in section 41-4303(2), Idaho Code, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide the protection stated in subsection (1) of this section, an association of insurers will pay benefits and continue coverages as provided for and limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

History.

I.C., § 41-4302, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4302 was repealed. See Prior Laws, § 43-4301.

41-4303. Coverage and limitations. — (1) This chapter shall provide

coverage for the policies and contracts specified in subsection (2) of this section:

(a) To persons, except for nonresident certificate holders under group policies or contracts who, regardless of where they reside, are the beneficiaries, assignees or payees of the persons covered under paragraph (b) of this subsection.

(b) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this chapter; and

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(c) For structured settlement annuities specified in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (d) and (e) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

1.(A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident; but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created in this chapter; and

2. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) The provisions of this chapter shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.

(e) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, the

provisions of this chapter shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) The provisions of this chapter shall provide coverage to the persons specified in subsection (1) of this section for direct, non-group life, health or annuity policies or contracts and for certificates under direct group policies and contracts and for supplemental contracts to any of these, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(b) The provisions of this chapter shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured including, but not limited to, benefits payable by an employer, association or other person under:

1. A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974, 29 U.S.C. section 1002(40);

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the

policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required in section 41-4309, Idaho Code, with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;
2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;
3. Misrepresentations of or regarding policy benefits;
4. Extra-contractual claims; or
5. A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) An unallocated annuity contract;

(xi) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 U.S.C. part C or 42 U.S.C. part D, commonly known as medicare parts C and D, or any regulations issued pursuant thereto.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b) Subject to the aggregate per life limitation in paragraph (c) of this subsection with respect to one (1) policy or contract:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) Three hundred thousand dollars ($300,000) in health insurance claims or benefit payments or one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for health benefits, except for major medical insurance as defined in section 41-4305, Idaho Code, and as provided for in subparagraph (iii) of this paragraph;

(iii) Five hundred thousand dollars ($500,000) for major medical insurance as defined in section 41-4305, Idaho Code;

(iv) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(v) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under paragraph (b) of this subsection, except with respect to benefits for major medical insurance as provided in paragraph (b)(iii) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one (1) life; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner; or

(d) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the provisions of this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(4) In performing its obligations to provide coverage under section 41-4308, Idaho Code, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

History.
I.C., § 41-4303, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4303 was repealed. See Prior Laws, § 43-4301.

Federal References.
Medicare parts C and D, referred to in paragraph (2)(b)(xii), are codified as 42 USCS § 1395w-21 et seq. and 42 USCS § 1395w-101, respectively.

Compiler's Notes.
For recent Moody's corporate average yields, see:
http://www.naic.org/research_moody.htm.
For Moody's Investors Service, Inc., see *http://www.moodys.com.*

41-4304. Construction. — The provisions of this chapter shall be construed to effect the purpose under section 41-4302, Idaho Code.

History.
I.C., § 41-4304, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4304 was repealed. See Prior Laws, § 43-4301.

41-4305. Definitions. — As used in this chapter:

(1) "Account" means any of the three (3) accounts maintained pursuant to section 41-4306, Idaho Code.

(2) "Association" means the Idaho life and health insurance guaranty association.

(3) "Authorized assessment" or "authorized," when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or "called," when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 41-4303, Idaho Code.

(7) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under section 41-4303, Idaho Code.

(8) "Director" means the director of the Idaho department of insurance.

(9) "Extra-contractual claims" shall include, for example, claims relating

to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

(10) "Impaired insurer" means a member insurer:

(a) Deemed by the director after the effective date of this chapter to be potentially unable to fulfill its contractual obligations and not an insolvent insurer; or

(b) Which, after the effective date of this chapter, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12)(a) "Major medical insurance" means, solely for purposes of this chapter, health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.

(b) "Major medical insurance" shall not include insurance policies, contracts or certificates:

(i) Issued by an insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance or specified disease or hospital confinement indemnity insurance; or

(ii) For medicare supplement insurance or for coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (CHAMPUS).

(13)(a) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 41-4303, Idaho Code, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn.

(b) "Member insurer" does not include:

(i) A hospital or medical service corporation or organization, whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange;

(vi) An organization that issues charitable gift annuities under section 41-120, Idaho Code;

(vii) A mutual benefit association;

(viii) A reciprocal insurer;

(ix) A limited managed care plan; or

(x) A self-funded health care plan.

(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.

(15) "Owner," "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who

is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(17)(a) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.

(b) "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 41-4303(2), Idaho Code, except that assessable premium shall not be reduced on account of section 41-4303(2)(b)(iii), Idaho Code, relating to interest limitations and section 41-4303(3)(b), (c) and (d), Idaho Code, relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(i) Premiums on an unallocated annuity contract; or

(ii) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18)(a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors contained in subparagraphs (i) through (v) of this paragraph.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) "Principal place of business" of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(20) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created in this chapter, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "State" means a state or a commonwealth of the United States, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(24) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History.

I.C., § 41-4305, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4305 was repealed. See Prior Laws, § 43-4301.

Federal References.
For civilian health and medical program for uniformed services (CHAMPUS), see 10 USCS § 1071.

Compiler's Notes.
The phrase "the effective date of this chapter" in paragraph (10)(a) refers to the effective date of S.L. 2011, ch. 196, which was effective July 1, 2011.

For recent Moody's corporate average yields, see:
http://www.naic.org/research_moody.htm.

For Moody's Investors Service, Inc., see *http://www.moodys.com.*

41-4306. Creation of the association. — (1) This chapter continues the existence of the nonprofit legal entity known as the Idaho life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 41-4310, Idaho Code, and shall exercise its powers through a board of directors provided for under section 41-4307, Idaho Code. For purposes of administration and assessment, the association shall continue the existence and maintenance of three (3) accounts:

(a) Life insurance account;

(b) Health insurance account, formerly designated the "disability insurance account"; and

(c) Annuity account.

(2) The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

History.
I.C., § 41-4306, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4306 was repealed. See Prior Laws, § 43-4301.

41-4307. Board of directors. — (1) The board of directors of the association shall consist of not fewer than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board of directors shall be selected by member insurers subject to the approval of the director. Vacancies on the board of directors shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director.

(2) In approving selections, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of

directors, but members of the board of directors shall not otherwise be compensated by the association for their services.

History.
I.C., § 41-4307, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4307 was repealed. See Prior Laws, § 43-4301.

41-4308. Powers and duties of the association. — (1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; and

(b) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination, pursuant to subparagraph (i) of this paragraph, of the benefits provided;

(iii) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv) of this paragraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

(iv)1. In providing the substitute coverage required under subparagraph (iii) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy; and

3. The association may reinsure any alternative or reissued policy;

(v)1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten; and

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or

alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under this paragraph (b) of this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 41-4303(2)(b)(iii), Idaho Code.

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to chapter 8, title 41, Idaho Code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require a written instrument of assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code, section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (a) through (d) of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 41-4309, Idaho Code, and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Reorganize itself with the prior written approval of the director from a nonprofit association into a corporation or other legal form of nonprofit entity permitted by the laws of the state of Idaho;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation.

(15) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter shall be in Ada county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the provisions of this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) A fixed interest rate;

(ii) Payment of dividends with minimum guarantees; or

(iii) A different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History.
I.C., § 41-4308, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4308 was repealed. See Prior Laws, § 43-4301.

Federal References.
Internal Revenue Code, section 130, referred to in paragraph (11)(c), is codified as 26 USCS § 130.

41-4309. Assessments. — (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board of directors finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 41-4308, Idaho Code, with regard to an impaired or an insolvent insurer.

(3)(a) The amount of a class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. The total of all non-pro rata assessments shall not exceed three hundred dollars ($300) per member insurer in any one (1) calendar year. The amount of a class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under this subsection and subsection (2) of this section and computation of assessments under this subsection shall be

made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) The total of all class B assessments authorized by the association with respect to a member insurer for each account shall not in one (1) calendar year exceed two percent (2%) of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in an account, does not provide in any one (1) year in an account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments.

A reasonable amount, as determined by the board of directors in its discretion, may be retained by the association in any account to provide funds for the continuing and future expenses of the association and for future loss claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the director for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and

priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with the request.

History.
I.C., § 41-4309, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4309 was repealed. See Prior Laws, § 43-4301.

41-4310. Plan of operation. — (1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty (30) days.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under section 41-4307, Idaho Code;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(f) Establish any additional procedures for assessments under section 41-4309, Idaho Code; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under section 41-4308(12)(c), Idaho Code, and section 41-4309, Idaho Code, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

History.
I.C., § 41-4310, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4310 was repealed. See Prior Laws, § 43-4301.

41-4311. Duties and powers of the director. — In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The director shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer; and

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.

(2) The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member

insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(3) A final action of the board of directors or the association may be appealed to the director by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the director shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the director.

(4) The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

History.
I.C., § 41-4311, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4311 was repealed. See Prior Laws, § 43-4301.

41-4312. Prevention of insolvencies. — (1) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the director to:

(a) Notify the insurance directors or commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:

(i) Revokes a license;

(ii) Suspends a license; or

(iii) Makes a formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(b) Report to the board of directors when the director has taken any of the actions set forth in paragraph (a) of this subsection or has received a report from any other director indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another director.

(c) Report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) Furnish to the board of directors the national association of insurance

commissioners (NAIC) insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board of directors may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

(2) The director may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the director of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies.

History.
I.C., § 41-4312, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4312 was repealed. See Prior Laws, § 43-4301.

Compiler's Notes.
The letters "NAIC" enclosed in parentheses so appeared in the law as enacted.

41-4313. Credits for assessments paid. — (1) A member insurer may offset against its premium tax liability to this state an assessment described in section 41-4309(8), Idaho Code, to the extent of twenty percent (20%) of the amount of the assessment for each of five (5) calendar years beginning with the premium tax due under section 41-402(4), Idaho Code, with respect to the year of payment of the assessment and thereafter with the premium tax due under section 41-402(4), Idaho Code, during each of the four (4) succeeding years. An allowable offset, or portion thereof, not used in any calendar year cannot be carried over or back to any other year.

(2) Any sums acquired by refund, pursuant to section 41-4309(6), Idaho Code, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund.

History.
I.C., § 41-4313, as added by 2011, ch. 196, § 2, p. 558; am. 2013, ch. 265, § 2, p. 650.

STATUTORY NOTES

Prior Laws.
Former § 41-4313 was repealed. See Prior Laws, § 43-4301.

Amendments.
The 2013 amendment, by ch. 265, substituted "five (5) calendar years beginning with the premium tax due under section 41-402(4), Idaho Code, with respect to the year of payment of the assessment and thereafter with the premium tax due under section 41-402(4), Idaho Code, during each of the four (4) succeeding years" for "the five (5) calendar years following the year in which the assessment was paid" in the first sentence in subsection (1) and deleted former subsection (3), which read: "Any sums acquired by refund, pursuant to section 41-4309(6), Idaho Code, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund."

41-4314. Miscellaneous provisions. — (1) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 41-4308, Idaho Code. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except upon the:

(a) Termination of the impairment or insolvency of the insurer; or

(b) Order of a court of competent jurisdiction.

Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 41-4315, Idaho Code.

(3) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 41-4308(11), Idaho Code. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer, as established in subsection (3) of this section and consistent with section 41-3334, Idaho Code, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within

one hundred twenty (120) days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 41-4308, Idaho Code, with respect to the insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b), (c) and (d) of this subsection.

(b) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

History.

I.C., § 41-4314, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4314 was repealed. See Prior Laws, § 43-4301.

41-4315. Examination of the association — Annual report. — The association shall be subject to examination and regulation by the director. The board of directors shall submit to the director each year, not later than May 1 of each year, a financial report in a form approved by the director and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

History.
I.C., § 41-4315, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4315 was repealed. See Prior Laws, § 43-4301.

41-4316. Tax exemptions. — The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

History.
I.C., § 41-4316, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4316 was repealed. See Prior Laws, § 43-4301.

41-4317. Immunity. — There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors or the director or the director's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

History.
I.C., § 41-4317, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4317 was repealed. See Prior Laws, § 43-4301.

41-4318. Stay of proceedings — Reopening default judgments. — All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

History.
I.C., § 41-4318, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4318 was repealed. See Prior Laws, § 43-4301.

41-4319. Prohibited advertisement of insurance guaranty association act in commercial sales. — No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Idaho life and health insurance guaranty association act. Provided however, that this section shall not apply to the Idaho life and health insurance guaranty association or any other entity which does not sell or solicit insurance. This section shall also not prohibit the furnishing of written information that is in a form prepared by the association and approved by the director upon request of the policy owner.

History.
I.C., § 41-4319, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.
Former § 41-4319 was repealed. See Prior Laws, § 43-4301.

41-4320. Application. — This chapter shall apply to coverage the guaranty association provides in connection with any member insurer that was first placed under an order of liquidation on or after January 1, 2011.

History.
I.C., § 41-4320, as added by 2011, ch. 196, § 2, p. 558.

CHAPTER 44

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

41-4410. Penalties.

RESEARCH REFERENCES

A.L.R. — State criminal prosecution against medical practitioner for fraud in connection with claims under medicaid, medicare, or similar welfare program for providing medical services. 79 A.L.R.6th 125.

CHAPTER 46

LONG-TERM CARE INSURANCE ACT

41-4601. Purpose.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

41-4605. Disclosure and performance standards for long-term care insurance.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

41-4606. Incontestability period.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

41-4607. Nonforfeiture benefits.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

41-4609. Administrative procedures.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

CHAPTER 47

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

SECTION.

41-4703. Definitions. — As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 41-4706, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Board" means the board of directors of the small employer [health] reinsurance program and the individual high risk reinsurance pool as provided for in section 41-5502, Idaho Code.

(6) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside

of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(8) "Catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to section 41-4705, Idaho Code.

(10) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.

(11) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(12) "Director" means the director of the department of insurance of the state of Idaho.

(13) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty (20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.

(14) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(15) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issues for a period of twelve (12) months or less.

(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and

(iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(d) The individual first becomes eligible.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established pursuant to section 41-4711, Idaho Code.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(a) The deductible/limit year used under the plan;

(b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(d) In any other case, the plan year is the calendar year.

(21) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(22) "Program" means the Idaho small employer [health] reinsurance program created in section 41-4711, Idaho Code.

(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool or any other similar publicly sponsored program; or

(b) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(25) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 41-4711, Idaho Code.

(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) "Risk-assuming carrier" means a small employer carrier whose application is approved by the director pursuant to section 41-4710, Idaho Code.

(28) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(29) "Small employer basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-4712, Idaho Code.

(30) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.

(31) "Small employer catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.

(32) "Small employer standard health benefit plan" means a health benefit plan developed pursuant to section 41-4712, Idaho Code.

History.

I.C., § 41-4703, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 2, p. 1337; am. 1995, ch. 360, § 2, p. 1235; am. 1997, ch. 321, § 12, p. 948; am. 1998, ch. 143, § 1, p. 507; am. 2000, ch. 472, § 2, p. 1602; am. 2001, ch. 296, § 8, p. 1044; am. 2003, ch. 267, § 1, p. 706; am. 2007, ch. 148, § 2, p. 427; am. 2009, ch. 125, § 8, p. 391; am. 2013, ch. 266, § 13, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the reference in subsection (10) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

For CHAMPUS statutes, see 10 USCS § 1071 et seq.

For Indian health service program, see 25 USCS § 1665a.

Compiler's Notes.

The bracketed insertions in subsections (5) and (22) were added by the compiler to reflect the correct, full name of the program created in § 41-4711.

CHAPTER 49

PETROLEUM CLEAN WATER TRUST FUND ACT

SECTION.

41-4903. Definitions. — For the purposes of this chapter:

(1) "Aboveground storage tank" means any one (1) or a combination of tanks, including pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of pipes connected thereto, is less than ten percent (10%) beneath the surface of the ground. This term does not include a heating tank, farm tank or residential tank or any tank with a capacity of one hundred ten (110) gallons or less.

(2) "Accidental release" means any sudden or nonsudden release of petroleum from a storage tank that results in a need for corrective action or compensation for bodily injury or property damage neither expected nor intended by the tank owner or operator.

(3) "Administrator" means the state insurance fund or any person employed by the board of trustees to replace the state insurance fund, employed by the board to administer the Idaho petroleum clean water trust fund.

(4) "Application fee" means the amount paid or payable by an owner or operator applying for a contract of insurance with the trust fund to offset the costs of issuing contracts of insurance and other costs of administering this fund.

(5) "Board" means the board of trustees appointed by the governor.

(6) "Bodily injury" means any bodily injury, sickness, disease or death sustained by any person and caused by an occurrence defined in subsection (19) of this section.

(7) "Contamination" means the presence of petroleum or petroleum products in surface or subsurface soil, surface water, or ground water.

(8) "Commission" means the state tax commission of the state of Idaho.

(9) "Corrective action" means those actions as are reasonably necessary

to satisfy applicable federal and state standards in the event of a release into the environment from a petroleum storage tank. Corrective action includes initial corrective action response or actions consistent with a remedial action to clean up contaminated soil and ground water or address residual effects after initial corrective action is taken, as well as actions necessary to monitor, assess and evaluate a release. Corrective action also includes the cost of removing a tank which is releasing or has been releasing petroleum products and the release cannot be corrected without removing the tank; but corrective action does not include the cost of replacing this tank with another tank.

(10) "Department" means the department of insurance of the state of Idaho.

(11) "Director" means the director of the department of insurance.

(12) "Farm tank" means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100) gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. "Farm" includes fish hatcheries, rangeland and nurseries with growing operations.

(13) "Free product" means petroleum or petroleum products in the nonaqueous phase, (e.g., liquid not dissolved in water).

(14) "Fund" or "trust fund" means the Idaho petroleum clean water trust fund.

(15) "Heating tank" means any tank with a capacity of more than one hundred ten (110) gallons situated above ground or underground which is used for storing heating oil for consumptive use on the premises where stored.

(16) "Legal defense costs" means any expense that an owner or operator or the trust fund incurs in defending against claims or actions brought by the federal environmental protection agency or a state agency to require corrective action or to recover the costs of corrective action; or by or on behalf of a third party for bodily injury or property damage caused by a release.

(17) "Licensed distributor" means any distributor who has obtained a license under the provisions of section 63-2427A, Idaho Code. If a person subject to the fee imposed by section 41-4909(7), Idaho Code, is not required to obtain a distributor's license under paragraph (a) or (b) of subsection (1) of section 63-2427A, Idaho Code, such person shall apply to the commission for a limited license for the purpose of complying with the requirements of this chapter. Such a limited license shall not be valid for any other purpose. No bond shall be required for a limited license. A holder of a limited license is a "licensed distributor" for the purposes of filing reports, paying fees and other actions necessary to the proper administration and enforcement of this chapter.

(18) "Noncommercial purposes" means not for resale, with respect to motor fuels.

(19) "Occurrence" means an accident, including continuous or repeated

exposure to conditions, which resulted in a release into the environment of petroleum products from a petroleum storage tank.

(20) "Operator" means any person in control, or having responsibility for, the daily operations of a petroleum storage tank.

(21) "Owner" means the owner of a petroleum storage tank, except that "owner" does not include any person who, without participation in the management of a petroleum storage tank, holds indicia of ownership primarily to protect the owner's security interest in the tank.

(22) "Person" means any corporation, association, partnership, one (1) or more individuals, or any governmental unit, or agency thereof, other than federal or state agencies.

(23) "Petroleum" and/or "petroleum products" mean crude oil, or any fraction thereof, which is liquid at standard conditions of temperature and pressure (i.e., at sixty (60) degrees fahrenheit and fourteen and seven-tenths (14.7) pounds per square inch absolute). The term includes motor gasoline, gasohol, other alcohol blended fuels, diesel fuel, heating oil and aviation fuel. Biodiesel and biodiesel blends, as those terms are defined in section 63-2401, Idaho Code, ethanol, and natural gasoline are also petroleum or petroleum products.

(24) "Property damage" means injury or destruction to tangible property caused by an occurrence.

(25) "Release" means any spilling, leaking, emitting, discharging, escaping, leaching, or disposing from a petroleum storage tank into ground water, surface water, or surface or subsurface soils.

(26) "Residential tank" means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100) gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on property used primarily for dwelling purposes.

(27) "Site" means a single parcel of property where petroleum or petroleum products are stored in a petroleum storage tank and includes all contiguous land, structures, other appurtenances, surface water, ground water, surface and subsurface soil, and subsurface strata within and beneath the property boundary.

(28) "State" means the state of Idaho or any office, department, agency, authority, commission, board, institution, hospital, college, university or other instrumentality thereof.

(29) "Tank" means a stationary device designed to contain an accumulation of petroleum or petroleum products and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

(30) "Trustees" means the trustees of the Idaho petroleum clean water trust fund, who are appointed by the governor pursuant to this chapter.

(31) "Underground storage tank" means any one (1) or combination of tanks, including underground pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of underground pipes connected thereto, is ten percent (10%) or more beneath the surface of the ground. This term does not include any:

(a) Farm or residential tank of one thousand one hundred (1,100) gallons or less capacity used for storing motor fuel for noncommercial purposes;
(b) Tank used solely for storing heating oil for consumptive use on the premises where stored;
(c) Septic tank;
(d) Pipeline facility including gathering lines regulated under:
(i) The natural gas pipeline safety act of 1968 (49 U.S.C. app. 1671, et seq.); or
(ii) The hazardous liquid pipeline safety act of 1979 (49 U.S.C. app. 2001, et seq.); or
(iii) State laws comparable to the provisions of the law referred to in paragraph (d)(i) or (d)(ii) of this subsection as an intrastate pipeline facility;
(e) Surface impoundment, pit, pond or lagoon;
(f) Storm water or wastewater collection system;
(g) Flow-through process tank;
(h) Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations;
(i) Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor;
(j) Tanks with a capacity of one hundred ten (110) gallons or less.

The term "underground storage tank" does not include any pipes connected to any tank which is described in paragraphs (a) through (i) of this definition.

(32) "Underground storage tank regulations" means regulations for petroleum storage tanks promulgated by the United States environmental protection agency (EPA) pursuant to subtitle I of the solid waste disposal act, as amended by the resource conservation and recovery act, regulations promulgated by the state of Idaho as part of a state program for underground storage tank regulation under subtitle I, or other regulations affecting underground storage tank operations and management, including the international fire code adopted by the state of Idaho.

History.

I.C., § 41-4903, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 2, p. 113; am. 1995, ch. 132, § 12, p. 565; am. 1998, ch. 428, § 6, p. 1346; am. 2002, ch. 86, § 9, p. 195; am. 2003, ch. 96, § 2, p. 281; am. 2007, ch. 37, § 3, p. 88; am. 2009, ch. 21, § 1, p. 48; am. 2011, ch. 6, § 1, p. 14.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 6, inserted "ethanol, and natural gasoline" near the end of subsection (23).

Federal References.

The natural gas pipeline safety act of 1968, referred to in paragraph (31)(d)(i), has been repealed. See now 49 USCS § 60101 et seq.

The hazardous liquid pipeline safety act of 1979, referred to in paragraph (31)(d)(ii), has been repealed. See 49 USCS § 60101 et seq.

For subtitle I of the solid waste disposal act, see 42 USCS § 6991 et seq.

The resource conservation and recovery act, referred to in subsection (32), is codified as 42 USCS § 6901 et seq.

41-4910. Distribution of application fees and transfer fees.

STATUTORY NOTES

Compiler's Notes.
This section was amended by S.L. 2009, ch. 333, § 3, effective July 1, 2010. The effective date of that amendment was changed by S.L. 2010, ch. 129, § 1 to July 1, 2011. However, S.L. 2011, ch. 68, § 2 repealed S.L. 2009, ch. 333, § 3, leaving the section as last amended by S.L. 2009, ch. 332, § 5.

CHAPTER 52

INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

SECTION.

41-5203. Definitions. — As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that an individual carrier is in compliance with the provisions of section 41-5206, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(4) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Carrier" means any entity that provides health insurance in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(6) "Case characteristics" means demographic or other objective characteristics of an individual that are considered by the individual carrier in the determination of premium rates for the individual, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(7) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.

(8) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives

more than one-half (½) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(9) "Director" means the director of the department of insurance of the state of Idaho.

(10) "Eligible individual" means an Idaho resident individual or dependent of an Idaho resident:

(a) Who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or

(b) Who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996 Public Law 104-191, Sec. 2741(b) (HIPAA)).

An "eligible individual" can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of title 41, Idaho Code.

(11) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(12) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(13) "Index rate" means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(15) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(16) "Individual catastrophic B health benefit plan" means a health benefit plan with limits higher than an individual catastrophic A health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(17) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to section 41-5511, Idaho Code.

(18) "Individual standard health benefit plan" means a health benefit plan developed pursuant to chapter 55, title 41, Idaho Code.

(19) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered or which could have been charged or

offered by the individual carrier to individuals with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(21) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or

(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(22) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a carrier participating in the Idaho individual high risk reinsurance pool established in chapter 55, title 41, Idaho Code.

(24) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(25) "Risk-assuming carrier" means a carrier whose application is approved by the director pursuant to section 41-5210, Idaho Code.

(26) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.

History.

I.C., § 41-5203, as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 8, p. 1235; am. 1997, ch. 321, § 20, p. 948; am. 2000, ch. 472, § 11, p. 1602; am. 2001, ch. 296, § 10, p. 1044; am. 2004, ch. 285, § 1, p. 802; am. 2005, ch. 353, § 1, p. 1111; am. 2007, ch. 148, § 4, p. 427; am. 2009, ch. 125, § 9, p. 391; am. 2013, ch. 266, § 14, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the reference in subsection (7) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

Part A or part B of title XVIII of the Social Security Act (medicare), referred to in subsection (10)(a) of this section, are compiled as 42 U.S.C.S., § 1395c et seq. and 42 U.S.C.S, § 1395j et seq. Title XIX of the Social Security Act (medicaid), also referred to in subsection (10)(a), is compiled as 42 U.S.C.S, § 1396 et seq.

"Eligible individual", referred to in subsection (10)(b), is defined for the federal health insurance portability and accountability act in 42 U.S.C.S. § 300gg-41(b).

For CHAMPUS statutes, see 10 USCS § 1071 et seq.

For Indian health service program, see 25 USCS § 1665a.

Compiler's Notes.
The abbreviations and words enclosed in parentheses so appeared in the law as enacted.

CHAPTER 54

RISK-BASED CAPITAL (RBC) FOR INSURERS ACT

41-5401. Definitions. [Effective January 1, 2015.] — As used in this chapter, these terms shall have the following meanings:

(1) "Adjusted RBC report" means an RBC report which has been adjusted by the director in accordance with section 41-5402(5), Idaho Code.

(2) "Corrective order" means an order issued by the director specifying corrective actions which the director has determined are required.

(3) "Domestic insurer" means any insurer domiciled in this state.

(4) "Foreign insurer" means any insurer not domiciled in this state.

(5) "Health organization" means any hospital service corporation or professional service corporation licensed under chapter 34, title 41, Idaho Code.

(6) "Insurer" means any insurance company authorized to transact insurance business in this state and includes a fraternal benefit society and a health organization unless the context otherwise requires.

(7) "Life and/or health insurer" means any insurer licensed under chapter 3, title 41, Idaho Code, to transact life, disability, accident and/or health insurance and includes any managed care organization within the scope of section 41-3921(1), Idaho Code, or a licensed property and casualty insurer writing only disability or accident and health insurance.

(8) "NAIC" means the national association of insurance commissioners.

(9) "Negative trend" means, with respect to a life and/or health insurer or a fraternal benefit society, a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the life or fraternal RBC instructions.

(10) "Property and casualty insurer" means any insurer licensed under chapter 3, title 41, Idaho Code, to transact property and casualty insurance, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, title insurers, farm and county mutuals and domestic reciprocal insurers with fewer than seven (7) subscribers which insure only worker's compensation risk in this state and which only issue fully assessable policies.

(11) "RBC" means risk-based capital.

(12) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be

amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(13) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC;

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(14) "RBC plan" means a comprehensive financial plan containing the elements specified in section 41-5403(2), Idaho Code. If the director rejects the RBC plan and it is revised by the insurer, with or without the director's recommendation, the plan shall be called the "revised RBC plan."

(15) "RBC report" means the report required in section 41-5402, Idaho Code.

(16) "Total adjusted capital" means the sum of:

(a) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under section 41-335, 41-3225 or 41-3425, Idaho Code; and

(b) Such other items, if any, as the RBC instructions may provide.

History.
I.C., § 41-5401, as added by 1996, ch. 96, § 1, p. 282; am. 2004, ch. 255, § 1, p. 726; am. 2014, ch. 319, § 1, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, rewrote the section, adding present subsections (5) and (6) and redesignating the subsequent subsections.

Compiler's Notes.
For this section as effective until January 1, 2015, see the bound volume.

As to national association of insurance commissioners, referred to in subsection (8), see *http://naic.org*.

Effective Dates.
Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

41-5402. RBC Reports. [Effective January 1, 2015.] — (1) Every domestic insurer shall, on or prior to each March 1 (the "filing date"), prepare and submit to the director a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance director in any state in which the insurer is authorized to do business, if the insurance director has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A life and health insurer's or fraternal benefit society's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer's or health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules and instructions referenced in this chapter is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

(5) If a domestic insurer files an RBC report which in the judgment of the director is inaccurate, then the director shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

History.

I.C., § 41-5402, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 2, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, inserted "or fraternal benefit society's" in the first sentence of the introductory language in subsection (2) and inserted "or health organization's" in the first sentence of the introductory

language in subsection (3).

Compiler's Notes.

For this section as effective until January 1, 2015, see the bound volume.

As to national association of insurance commissioners (NAIC), referred to in paragraph (1)(a), see *http://naic.org*.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

41-5403. Company action level event. [Effective January 1, 2015.] — (1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by an insurer which indicates that:

(i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) If a life and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend; or

(iii) If a property or casualty insurer, health organization or health insurer that completes the health annual statement for the reporting year, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health RBC instructions;

(b) The notification by the director to the insurer of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under section 41-5407, Idaho Code; or

(c) If, pursuant to section 41-5407, Idaho Code, an insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the director an RBC plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, and for managed care organizations and health organizations for at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's business, including but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five (45) days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report pursuant to section 41-5407, Idaho Code, within forty-five (45) days after notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(4) Within sixty (60) days after the submission by an insurer of an RBC plan to the director, the director shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the director, unsatisfactory. If the director determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the director. Upon notification from the director, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the director, and shall submit the revised RBC plan to the director:

(a) Within forty-five (45) days after the notification from the director; or

(b) If the insurer challenges the notification from the director under section 41-5407, Idaho Code, within forty-five (45) days after a notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the director to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the director may, at the director's discretion, subject to the insurer's right to a hearing under section 41-5407, Idaho Code, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files an RBC plan or revised RBC plan with the director shall file a copy of the RBC plan or revised RBC plan with the insurance director in any state in which the insurer is authorized to do business if:

(a) Such state has an RBC provision substantially similar to section 41-5408(1), Idaho Code; and

(b) The insurance director of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section.

History.
I.C., § 41-5403, as added by 1996, ch. 96, § 1, p. 282; am. 2007, ch. 277, § 1, p. 80; am. 2014, ch. 319, § 3, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, in subsection (1), in paragraph (a)(ii), inserted "that completes the life annual statement for the reporting year or fraternal benefit society" and "3.0" for "2.5", and, in paragraph (a)(iii) inserted "health organization or health insurer that completes the health annual statement for the reporting year" near the beginning and "or health" following "casualty"; and inserted "and for managed care organizations and health organizations for at least the two (2) succeeding years" in the first sentence of paragraph (2)(c).

Compiler's Notes.
For this section as effective until January 1, 2015, see the bound volume.

Effective Dates.
Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

41-5406. Mandatory control level event. [Effective January 1, 2015.] — (1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the director to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under section 41-5407, Idaho Code; or

(c) If, pursuant to section 41-5407, Idaho Code, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) With respect to a life and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society, the director shall take such actions as are necessary to place the insurer under regulatory control pursuant to chapter 33, title 41, Idaho Code. In that event, the mandatory control level event shall be deemed sufficient grounds for the director to take action pursuant to chapter 33, title 41, Idaho Code, and the director shall have the rights, powers and duties with respect to the insurer as are set forth in chapter 33, title 41, Idaho Code. If the director takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of section 41-3309, Idaho Code, pertaining to summary proceedings. Notwithstanding any of the foregoing, the director may forgo action for up to ninety (90) days after the mandatory control level event if the director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

(b) With respect to a property and casualty insurer, health organization or health insurer that completes the health annual statement for the reporting year, the director shall take such actions as are necessary to place the insurer under regulatory control pursuant to chapter 33, title 41, Idaho Code, or, in the case of an insurer which is writing no business

and which is running off its existing business, may allow the insurer to continue its run off under the supervision of the director. In either event, the mandatory control level event shall be deemed sufficient grounds for the director to take action pursuant to chapter 33, title 41, Idaho Code, and the director shall have the rights, powers and duties with respect to the insurer as are set forth in chapter 33, title 41, Idaho Code. If the director takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of section 41-3309, Idaho Code, pertaining to summary proceedings. Notwithstanding any of the foregoing, the director may forgo action for up to ninety (90) days after the mandatory control level event if the director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

History.
I.C., § 41-5406, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 4, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, substituted "and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society" for "insurer" near the beginning of paragraph (2)(a) and inserted "health organization or health insurer that completes the health annual statement for the reporting year" near the beginning of paragraph (2)(b).

Compiler's Notes.
For this section as effective until January 1, 2015, see the bound volume.

Effective Dates.
Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

41-5408. Confidentiality — Prohibition on announcements, prohibition on use in ratemaking. [Effective January 1, 2015.] — (1) All RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the director pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer which are filed with the director, constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the director and shall be considered privileged. Notwithstanding the provisions of chapter 3, title 9, Idaho Code, this information shall not be made public or be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties.

(2) Neither the director nor any person who received documents, materials or other information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information obtained or provided pursuant to subsection (1) of this section.

(3) In order to assist in the performance of his duties under this chapter, the director may:

(a) Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other states, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(b) Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material or information received with notice of or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) Enter into agreements governing the sharing and use of information consistent with the provisions of this subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information referenced in this section shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subsection (3) of this section.

(5) It is the judgment of the legislature that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the insurers' RBC levels is published in any written publication and the insurer is able to demonstrate to the director with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(6) It is the further judgment of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are

intended solely for use by the director in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the director for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the director to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

History.
I.C., § 41-5408, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 5, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, in subsection (1), inserted "and shall be considered privileged" at the end of the first sentence, rewrote the second sentence, and added the last sentence; inserted present subsections (2) through (4), and redesignated the subsequent subsections accordingly.

Compiler's Notes.
For this section as effective until January 1, 2015, see the bound volume.

Effective Dates.
Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

41-5409. Supplemental provisions — Rules — Exemption. [Effective January 1, 2015.] — (1) The provisions of this chapter are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the director under such laws, including, but not limited to, chapter 33, title 41, Idaho Code, and rules adopted by the department of insurance relating to the director's authority for companies deemed to be in hazardous financial condition.

(2) The director may adopt reasonable rules necessary for the implementation of this chapter in accordance with the provisions of chapter 52, title 67, Idaho Code.

(3) Upon written application, the director may exempt from compliance with this chapter, for a specified period or periods, any domestic property and casualty insurer, domestic managed care organization or domestic health organization which:

(a) Writes direct business only in this state; and

(b) Writes direct annual premiums of two million dollars ($2,000,000) or less; and

(c) Assumes no reinsurance in excess of five percent (5%) of direct premium written; or

(d) Is a managed care organization offering only a limited managed care plan, a hospital service corporation or a professional service corporation that covers less than two thousand (2,000) lives.

History.
I.C., § 41-5409, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 6, p. 785.

STATUTORY NOTES

Amendments.
The 2014 amendment, by ch. 319, in subsection (3), inserted "domestic managed care organization or domestic health organization"

in the introductory language and added paragraph (d).

Compiler's Notes.

For this section as effective until January 1, 2015, see the bound volume.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

CHAPTER 59

IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT

41-5903. Definitions. — For purposes of this chapter:

(1) "Administrative record" means all nonprivileged documents, records or other health information which was submitted, considered, generated or relied upon by the health carrier in the course of making the adverse benefit determination, including, but not limited to, documents, records or other information that constitutes the plan's policy statements or guidance concerning the denied treatment or benefit, all records provided by the covered person or the covered person's medical care provider related to the denied treatment or benefit, all records provided to an independent review organization as part of the independent review of the denied treatment or benefit and the opinion issued by the independent review organization.

(2) "Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, and the requested service or payment for the service is therefore terminated, denied or reduced.

(3) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(4) "Authorized representative" means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(5) "Best evidence" means evidence based on randomized clinical trials.

(a) If randomized clinical trials are not available, then cohort studies or case-control studies;

(b) If studies in paragraph (a) of this subsection (5) are not available, then case-series.

(6) "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

(7) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(10) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(11) "Cohort study" means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention(s).

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(13) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms and conditions of a health benefit plan.

(14) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(15) "Director" means the director of the Idaho department of insurance.

(16) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(17) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(18) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(19) "Expedited external review" is the procedure available for urgent care requests for external review.

(20) "Expert" means a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(21) "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled

nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

(22) "Final adverse benefit determination" means an adverse benefit determination, as defined in section 41-5903(2), Idaho Code, involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the covered person's health benefit plan.

(23) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(24) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(25) "Health care provider" or "provider" means a health care professional or a facility.

(26) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(27) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a disability insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

(28) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of health care services to an individual; or

(c) Payment for the provision of health care services to an individual.

(29) "Independent review organization" means an entity that conducts independent external reviews of final adverse benefit determinations.

(30) "Investigational" means the definition provided in the covered person's health benefit plan; if the health benefit plan does not provide a definition of "investigational," it shall be defined as follows: Any treatment, procedure, facility, equipment, drug, device or commodity, regardless of its medical necessity, which is experimental, or in the early developmental stage of medical technology, for which there are no randomized clinical trials or, absent such trials, for which there are no cohort studies or case-control studies or, absent such studies, then for which there is no case-series. The determination by the health carrier will be based on objective data and information obtained by the health carrier and reviewed, by competent medical personnel, according to the following:

(a) The technology has final approval from the appropriate government regulatory bodies;

(b) Medical or scientific evidence regarding the technology is sufficiently

comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the technology;

(c) The technology's overall beneficial effects on health outweigh the overall harmful effects on health; and

(d) The technology is as beneficial as any established alternative.

When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of paragraphs (c) and (d) of this subsection (30).

(31) "Medically necessary" or "medical necessity" means the definition provided in the covered person's health benefit plan; if the covered person's health benefit plan does not define "medically necessary" or "medical necessity," these terms shall mean health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease;

(c) Not primarily for the convenience of the covered person, physician or other health care provider; and

(d) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible medical or scientific evidence.

(32) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd. for indexing in excerpta medicus [medica] (EMBASE);

(c) Medical journals recognized by the U.S. secretary of health and human services under section 1861(t)(2) of the federal social security act;

(d) The following standard reference compendia:

(i) The American hospital formulary service — drug information;

(ii) Drug facts and comparisons;

(iii) The United States pharmacopoeia — drug information; and

(iv) The American dental association accepted dental therapeutics.

(e) Findings, studies or research conducted by or under the auspices of

federal government agencies and nationally recognized federal research institutes, including:

(i) The federal agency for healthcare research and quality;

(ii) The national institutes of health;

(iii) The national cancer institute;

(iv) The national academy of sciences;

(v) The centers for medicare and medicaid services;

(vi) The federal food and drug administration; and

(vii) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

(f) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (a) through (e) of this subsection (32).

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(34) "Post service review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(35) "Pre-service review" means utilization review conducted prior to an admission or a course of treatment.

(36) "Protected health information" means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(37) "Randomized clinical trial" means a controlled, prospective study of patients who have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(38) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(39) "Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;

(b) In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or

(c) The treatment would be significantly less effective if not promptly initiated.

The opinion of the covered person's treating health care professional with knowledge of the covered person's medical condition that a request is an urgent care request should be treated with deference.

(40) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, pre-service review, second opinion, certification, concurrent review, case management, discharge planning or post service review.

(41) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

History.

I.C., § 41-5903, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 1, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" near the end of subsection (2) and inserted "a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or" in the introductory paragraph in subsection (39).

Federal References.

Section 1861(t)(2) of the federal social security act, referred to in paragraph (32)(c), is compiled as 42 USCS § 1861(t)(2).

Compiler's Notes.

For list of journals indexed for national institutes of health's national library of medicine (MEDLINE), see:

http://www.nlm.nih.gov/tsd/serials/lji.html.

For elsevier science's excerpta medica, see *http://www.elsevier.com/wps/find/journaldescription.cws_home/600580/description.*

For drug information from the American hospital formulary service, see *http://www.ahfsdruginformation.com.*

For United States pharmacopoeia, see *http://www.usp.org.*

The bracketed insertion in paragraph (32)(b) was added by the compiler to correct the name of the referenced publication.

41-5904. Applicability and scope. — (1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers.

(2) The provisions of this chapter shall not apply to a plan, policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; nor shall this chapter apply to a credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, limited benefit health plans or any other limited supplemental benefit; nor shall this chapter apply to a medicare advantage plan or medicare supplemental policy of insurance, as defined by the director by rule, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55, title 10, of the United States Code and any coverage issued as supplemental to that coverage; nor shall this chapter apply to any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; nor shall this chapter apply to a

single employer self-funded employee benefit plan subject to and operated in compliance with the employee retirement income security act of 1974 (ERISA); provided however, the single employer self-funded ERISA employee benefit plan administrator or designee may, by timely and appropriate written notice to the director, voluntarily elect to comply with the provisions of this chapter either for a single plan beneficiary or for a specific period of time. The director may promulgate rules establishing the procedure for an employee benefit plan administrator or designee, to voluntarily comply with the provisions of this chapter and to provide for an administrative fee to be paid by the employee benefit plan administrator for each voluntary external review request submitted to the department pursuant to this chapter.

(3) The availability or use of external review pursuant to this chapter shall not alter the standard of review used by a court of competent jurisdiction when adjudicating the health carrier's final adverse benefit determination.

History.
I.C., § 41-5904, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 2, p. 333; am. 2011, ch. 258, § 1, p. 703.

STATUTORY NOTES

Amendments.
This section was amended by two 2011 acts which appear to be compatible and have been compiled together.

The 2011 amendment, by ch. 122, deleted "final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply" from the end of subsection (1).

The 2011 amendment, by ch. 258, deleted "final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply" from the end of subsection (1); and, in subsection (2), added the proviso at the end of the first sentence and added the last sentence.

Federal References.
Chapter 55 of title 10 of the United States Code, referred to in subsection (2), is codified as 10 USCS § 1071 et seq.

The employee retirement income security act of 1974, referred to in subsection (2), is codified as 29 USCS § 1001 et seq.

41-5905. Notice of right to external review. — (1) When a final adverse benefit determination is made, the health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, and include the appropriate statements and information set forth in subsection (2) of this section at the same time the health carrier sends written notice of the final adverse benefit determination.

(2) The director may prescribe by rule the form and content of the notice required under this section, which shall include:

(a) The following, or substantially equivalent, language:

> "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or your health care service or supply was denied based upon

a determination that it was investigational. You may request an external review by submitting a written request to the department of insurance."

The notice shall include contact information for the department of insurance, including the website, address and telephone number.

(b) If the adverse benefit determination is for a pre-service or concurrent service, the health carrier shall notify the covered person of the right to an expedited external review if the request is an urgent care request. The notification shall include the definition of urgent care request.

(c) The health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 41-5916, Idaho Code, highlighting the provisions in the external review procedures that give the covered person the opportunity to submit additional information, and include any forms used to process an external review.

(d) The health carrier shall include an authorization form, or other document approved by the director, that complies with the requirements of 45 CFR section 164.508, by which the covered person, for purposes of conducting an external review pursuant to this chapter, authorizes the health carrier and the covered person's treating health care providers to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review. Until the director receives this form from the covered person, duly executed, the external review process is stayed and the health carrier has no obligations under this chapter.

History.

I.C., § 41-5905, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 3, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, substituted "When a final adverse benefit determination is made" for "If at the conclusion of the health carrier's internal grievance process the decision is adverse to the covered person, based upon a determination that the service or supply to be provided or which was provided did not meet medical necessity criteria or is investigational" at the beginning of subsection (1); in paragraph (2)(a), inserted "appropriateness, health care setting, level of care or effectiveness"; and, in subsection (2)(b), deleted "and was denied based upon a failure to meet medical necessity criteria or because the service was determined to be investigational" following "concurrent service."

41-5906. Request for external review. — A covered person may make a request for an external review of a final adverse benefit determination. Except for a request for an expedited external review as set forth in section 41-5909, Idaho Code, all requests for external review shall be made in writing to the director. The director may prescribe by rule the form and content of external review requests required to be submitted under this section.

History.
I.C., § 41-5906, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 4, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, substituted "for" for "to" in the section heading and deleted the former last sentence, which read: "The director shall prescribe by rule the amount of the administrative filing fee, if any, to be paid by the covered person when the external review request is submitted."

41-5907. Exhaustion of internal grievance process. — (1) Except as provided in subsection (2) of this section, a request for an external review pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, shall not be made until the covered person has exhausted the health carrier's internal grievance process. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person:

(a) Has filed and completed a grievance, involving an adverse benefit determination, according to the terms and conditions of the covered person's health benefit plan; or

(b) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty-five (35) days following the date the covered person filed the grievance with the health carrier, or the covered person filed a grievance on an urgent care request on a pre-service or concurrent care adverse benefit determination and has not received a determination from the health carrier within three (3) business days after filing.

(2) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in the health carrier's grievance appeal process whenever:

(a) The health carrier agrees to waive the exhaustion requirement;

(b) The health carrier has failed to strictly follow its duties in affording a timely, full and fair opportunity for the covered person to take advantage of the internal grievance procedures; or

(c) The urgent care request involves a medical condition for which the time frame for completion of the carrier's internal grievance process pursuant to this section would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person has applied for expedited external review at the same time as applying for an expedited internal review.

History.
I.C., § 41-5907, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 5, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, added present paragraphs (2)(b) and (2)(c), and made related redesignations; and deleted former subsection (2), which read: "If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection (1)(b) of this section, the covered person may file a request in writing for a standard external review, or where appropriate, an expedited external review."

41-5908. Standard external review. — (1) Within four (4) months after the date of issuance of a notice of a final adverse benefit determination pursuant to section 41-5905, Idaho Code, a covered person may file a request for an external review with the director. The request shall be made on such form as may be designated by the director.

(2) Within seven (7) days after the date of receipt of a request for external review pursuant to subsection (1) of this section, the director shall send a copy of the request to the health carrier.

(3) Within fourteen (14) days following the date of receipt of the copy of the external review request from the director pursuant to subsection (2) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a post service review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) The health care service that is the subject of the final adverse benefit determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or the service or supply is investigational;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the covered person's health benefit plan, unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 41-5907, Idaho Code; and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 41-5905(2)(d), Idaho Code.

(4) Within five (5) business days after completion of the preliminary review, the health carrier shall notify the director and covered person in writing whether the request is complete and whether the request is eligible for external review.

(5) If the request is not complete, the health carrier shall inform the covered person and the director in writing and include in the notice what information or materials are needed to make the request complete.

(6) If the request is not eligible for external review, the health carrier shall inform the covered person and the director in writing and include in the notice the reasons for its ineligibility.

(7) The director may prescribe by rule the form for the health carrier's notice of initial determination under this section and any supporting

information to be included in the notice. The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that the external review request is ineligible for review, may be appealed to the director.

(8) The director may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review. The director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(9) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, within seven (7) days after the date of receipt of the notice, the director shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code, to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify, in writing, the covered person of the request's eligibility and acceptance for external review.

(c) The director shall include in the notice provided to the covered person a statement that the covered person may submit, in writing, to the assigned independent review organization within seven (7) days following the date of receipt of the notice provided pursuant to subsection (9)(b) of this section, additional information that the independent review organization shall consider when conducting the external review.

(10) In reaching a decision, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(11) Within fourteen (14) days after the date of receipt of the notice provided pursuant to subsection (9)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.

(12) Except as provided in subsection (13) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subsection (11) of this section, shall not delay the conduct of the external review.

(13) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subsection (11) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination.

(14) Within one (1) business day after making the decision to terminate the external review pursuant to subsection (13) of this section, the indepen-

dent review organization shall notify the covered person, the health carrier and the director.

(15) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) of this section, and any other information submitted in writing to the independent review organization by the covered person pursuant to subsection (9)(c) of this section; provided however, that if the covered person does submit new information in writing to the independent review organization pursuant to subsection (9)(c) of this section, then the health carrier is entitled to seven (7) days following its receipt thereof to submit additional responsive information to the internal review organization.

(16) Upon receipt of any information submitted by the covered person pursuant to subsection (9)(c) of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

(17) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (16) of this section, the health carrier may reconsider its adverse determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The assigned independent review organization shall review all of the information and documents received pursuant to subsection (15) of this section.

(18) The external review may be terminated if the health carrier decides to reverse its final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the final adverse benefit determination. Within two (2) business days after making the decision to reverse its final adverse benefit determination, the health carrier shall notify the covered person, the assigned independent review organization and the director in writing of its decision.

(19) In addition to the documents and information provided pursuant to subsection (11) of this section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include the applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional

medical societies, boards and associations, health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;

(g) Medical or scientific evidence, as defined in section 41-5903(32), Idaho Code;

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (19) to the extent the information or documents are available.

(20) Within forty-two (42) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the final adverse benefit determination to the covered person, the health carrier and the director. The independent review organization shall include in the notice:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the director to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including an explanation of the scientific or clinical judgment applied to reach its decision;

(f) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision; and

(g) References to the terms and conditions of the health benefit plan at issue, including an explanation of how its decision is consistent with them.

(21) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to section 41-5912, Idaho Code.

(22) Upon receipt of a notice of a decision pursuant to subsection (20) of this section reversing the adverse benefit determination or final adverse benefit determination, the health carrier shall approve as soon as reasonably practicable but not later than one (1) business day after receipt of the notice the coverage that was the subject of the adverse benefit determination or final adverse benefit determination.

History.

I.C., § 41-5908, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 6, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" in subsection (3)(b); sub-

stituted the last occurrence of "independent" for "internal" in subsection (15); and added subsection (22).

41-5909. Expedited external review. — (1) A covered person may make a request for an expedited external review of a pre-service or concurrent service adverse benefit determination where the requested service meets the definition of an urgent care request and the covered person has exhausted the health carrier's internal grievance process or is entitled to request external review before exhausting the health carrier's internal grievance process as provided in section 41-5907, Idaho Code.

(2) Upon receipt of a request for an expedited external review, the director shall send a copy of the request to the health carrier.

(3) Upon receipt of the request pursuant to subsection (2) of this section, the health carrier shall determine, as soon as possible but not later than the second full business day thereafter, whether the carrier agrees that the request meets the reviewability requirements set forth in section 41-5908(3), Idaho Code. The health carrier shall notify the director and the covered person of its eligibility determination as soon as reasonably practicable but not later than one (1) business day after making the determination.

(a) The director may prescribe by rule the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that an external review request is ineligible for review, may be appealed to the director.

(4) The director may determine that a request is eligible for external review pursuant to section 41-5908(3), Idaho Code, notwithstanding a health carrier's initial determination that the request is ineligible, and require that it be referred for external review. In making a determination under this subsection (4), the director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the director shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code. The director shall notify the health carrier and the covered person of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection (9) of this section, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's internal grievance process.

(7) Upon receipt of the notice from the director of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection (5) of this section, the health carrier or its

designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse benefit determination and the final adverse benefit determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(8) In addition to the documents and information provided or transmitted pursuant to subsection (7) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's pertinent medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;

(d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, the health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization in making the adverse benefit determination;

(g) Medical or scientific evidence, as defined in section 41-5903(32), Idaho Code;

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (8) to the extent the information and documents are available.

(9) As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 41-5908(3), Idaho Code, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the final adverse benefit determination; and

(b) Notify the covered person, the health carrier and the director of the decision.

(10) If the notice provided pursuant to subsection (9)(b) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, the health carrier and the director, which shall include an explanation of the scientific or clinical judgment for the determination; and

(b) Include the information set forth in section 41-5908(20), Idaho Code.

(11) Upon receipt of the notice of a decision pursuant to subsection (10) of this section reversing the final adverse benefit determination, the health carrier shall notify the director and the covered person of its intent to pay the covered benefit as soon as reasonably practicable but not later than one (1) business day after receiving the notice of decision.

(12) An expedited external review shall not be provided for post service final adverse benefit determinations.

(13) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to section 41-5912, Idaho Code.

History.
I.C., § 41-5909, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 7, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, in subsection (1), deleted "After having exhausted the health carrier's internal grievance process as provided in section 41-5907, Idaho Code" from the beginning, deleted "based on medical necessity or investigational" following "determination," and added "and the covered person has exhausted the health carrier's internal grievance process or is entitled to request external review before exhausting the health carrier's internal grievance process as provided in section 41-5907, Idaho Code"; in paragraph (10)(a), deleted "addressing the medical necessity criteria as defined in this chapter or, where the appeal is based upon a denial of a service as investigational, addressing the criteria for determination of investigational status as defined in this chapter" from the end; and, in subsection (11), substituted "its intent to pay the covered benefit" for "its eligibility determination" and substituted "after receiving the notice of decision" for "after making the determination."

41-5915. Funding of external review. — The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the reasonable cost of the independent review organization for conducting the external review.

History.
I.C., § 41-5915, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 8, p. 333.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 122, deleted the former last sentence, which read: "The director may provide by rule for an administrative fee to offset the department's costs associated with external review to be paid by the covered person at the time he makes a request for external review."

41-5916. Disclosure requirements. — (1) Each health carrier shall include a summary description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or

other evidence of coverage it provides to covered persons. The disclosure shall be in a format prescribed by the director.

(2) The description required under subsection (1) of this section shall include:

(a) A statement that informs the covered person of the right of the covered person to file a request for an external review of a final adverse benefit determination with the director;

(b) An explanation that external review and, in certain circumstances, expedited external review are available when the final adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or investigational service or supply;

(c) The website, telephone number and address of the director; and

(d) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review including any judicial review of the external review decision pursuant to ERISA, if applicable.

(e) If the health plan is not subject to ERISA, a statement informing the covered person that the plan is not subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on both the covered person and the health carrier, as provided in section 41-5910, Idaho Code. If the health plan is subject to ERISA, the statement shall inform the covered person that the plan is subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on the health carrier but not the covered person, as provided in section 41-5910, Idaho Code, and that the covered person may have the right to judicial review under ERISA in a court of competent jurisdiction.

History.

I.C., § 41-5916, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 9, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" in paragraph (2)(b).

Federal References.

ERISA, the employee retirement income security act of 1974, referred to in this section, is codified as 29 USCS § 1001 et seq.

CHAPTER 60

IMMUNIZATION ASSESSMENTS

41-6001. Legislative intent. [Null and void, effective July 1, 2015.] — The intent of the legislature is to provide a supplemental funding mechanism for the Idaho immunization program administered by the Idaho department of health and welfare, by creating a dedicated vaccine fund and an independent board, which board is empowered to assess fees from all carriers. The chapter's goal is to ensure access to childhood vaccinations in Idaho, by decreasing costs and enabling the maintenance of a single distribution of vaccines available to health care providers in Idaho who administer the vaccines to program eligible children.

History.
I.C., § 41-6001, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6002. Definitions. [Null and void, effective July 1, 2015.] — As used in this chapter:

(1) "Board" means the Idaho immunization assessment board created by section 41-6003, Idaho Code.

(2) "Carrier" means: any entity subject to regulation by the department that provides or is authorized to provide health insurance or health benefit plans, or that administers health insurance or health benefit coverage or that otherwise provides a plan of health insurance or health benefits; or a foreign insurer who provides health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state. For purposes of this chapter, the term "carrier" includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a managed care organization, entities that provide excess or stop-loss insurance, and persons or entities required to be registered with the director under chapter 9, title 41, Idaho Code. For the purposes of this chapter, the term "carrier" does not include an entity that only issues policies, certificates or subscriber contracts within the state of Idaho that are limited to a specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(3) "Director" means the director of the department of insurance of the state of Idaho.

(4) "Fund" means the Idaho immunization dedicated vaccine fund created in section 41-6007, Idaho Code.

(5) "Idaho immunization program" means that program administered by the Idaho department of health and welfare to provide vaccinations against diseases to Idaho children consistent with Idaho and federal law.

(6) "Plan of operation" means the plan of operation of the fund as established by the board.

(7) "Program-eligible child" means any child, natural or adopted, who is under nineteen (19) years of age, whose custodial parent or legal guardian resides in Idaho and who is not eligible for the federal vaccines for children program.

(8) "Vaccine" means any preparations of killed microorganisms, living attenuated organisms or living fully virulent organisms that are approved by the federal food and drug administration and recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

(9) "Vaccines for children" program is that federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the social security act.

History.
I.C., § 41-6002, as added by 2010, ch. 32, § 1, p. 60; am. 2010, ch. 187, § 1, p. 399.

STATUTORY NOTES

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6003. Idaho immunization assessment board. [Null and void, effective July 1, 2015.] — (1) There is hereby created in the Idaho department of insurance the Idaho immunization assessment board. The board will perform an essential governmental function in the exercise of powers conferred upon it by this chapter and shall be a governmental entity within the meaning of chapter 9, title 6, Idaho Code.

(2) The board shall consist of nine (9) members and one (1) ex officio member:

(a) Six (6) members shall be appointed by the director and serve at the pleasure of the director. In selecting the members of the board, the director shall appoint:

(i) Three (3) members representing carriers, one (1) of whom shall represent administrators or third party administrators;

(ii) One (1) primary care physician licensed and practicing in Idaho; and

(iii) Two (2) members representing the Idaho business community.

(b) One (1) member appointed by the director of the department of health and welfare;

(c) One (1) member shall be a member of the senate, appointed by the president pro tempore of the senate;

(d) One (1) member shall be a member of the house of representatives, appointed by the speaker of the house of representatives; and

(e) The director or his designated representative shall serve as an ex officio tenth member of the board.

(3) The initial board members appointed by the director pursuant to subsection (2)(a) of this section shall be appointed as follows: Legislative members of the board shall serve for a term of two (2) years.

(a) Two (2) members, as determined by the director, shall serve an initial term of two (2) years;

(b) Two (2) members, as determined by the director, shall serve an initial term of three (3) years; and

(c) One (1) member, as determined by the director, shall serve an initial term of four (4) years.

Subsequent board members appointed by the director pursuant to subsection (2)(a) of this section shall serve for terms of three (3) years.

(4) A vacancy on the board appointed by the director pursuant to subsection (2)(a) of this section shall be filled by the director. A vacancy in a legislative member's position on the board shall be filled in the same manner as the original appointment.

(5) Except for employees of the state of Idaho, members of the board shall not receive compensation or reimbursement for expenses for their service on the board. Employees of the state of Idaho serving on the board shall be reimbursed for their vouched expenses associated with their service on the board in a manner consistent with policy for other state employees.

History.
I.C., § 41-6003, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6004. Plan of operation. [Null and void, effective July 1, 2015.] — (1) The board shall submit to the director a plan of operation and thereafter any amendments thereto. The plan of operation, and any amendments thereto, shall become effective upon written approval by the director. If the board fails to submit a suitable plan of operation, the director shall adopt and promulgate a temporary plan of operation.

(2) The plan of operation shall:

(a) Identify methodology and procedures for determining assessments to the carriers that are fair and equitable;

(b) Establish procedures for the director to collect assessments from carriers to fund vaccine purchases by the state of Idaho; and

(c) Provide for any additional matters necessary for the implementation and administration of the fund.

(3) Administrative cost associated with the creation and amending the plan of operation shall be paid out of the fund.

History.
I.C., § 41-6004, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6005. Power and liability of the board. [Null and void, effective July 1, 2015.] — (1) The board shall have the power to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including contracts for administrative services;

(b) Determine the method of assessment and assess carriers in accordance with the provisions of section 41-6006, Idaho Code;

(c) Require carriers to provide to the board such statements and reports the board deems necessary to fulfill its duties under this chapter;

(d) Establish policies and procedures as may be necessary or convenient for the implementation of this chapter and the operation of the assessments authorized by this chapter; and

(e) Consult with the Idaho department of health and welfare and other experts as the board may deem appropriate as necessary or proper to carry out the provisions and purposes of this chapter.

(2) Neither the board nor its members shall be liable for any obligations of the vaccine assessments. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. Participation by a carrier in the assessments authorized by this chapter or on the board under the provisions of this chapter shall not be grounds for any legal action, criminal or civil liability, or penalty against the fund or any of its carriers or board members, either jointly or separately.

History.
I.C., § 41-6005, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 1, p. 331.

STATUTORY NOTES

Amendments.
The 2011 amendment, by ch. 121, added "including contracts for administrative services" in paragraph (1)(a) and added paragraph (1)(e).

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6006. Assessments. [Null and void, effective July 1, 2015.] — (1) The department of health and welfare shall report to the board on or before January 1 the total number of program eligible children in the Idaho immunization reminder information system registry who received vaccines, the doses and the total nonvaccine-for-children funds expended for vaccines purchased and administered through the Idaho immunization program for the previous state fiscal year and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter.

(2) The assessments to fund vaccine purchases for program eligible children shall be made annually by the board. Each carrier's proportion of the assessment and the dates upon which the carrier must pay the assessment into the fund shall be determined by the board based on annual statements and other reports deemed necessary by the board. In making the assessment determination, the board shall consider such factors as any surplus funds remaining from a prior assessment, the number and cost of vaccine doses expected to be administered in the pertinent time period and the number of program eligible children in the pertinent time period, as well as any necessary costs and expenses to administer the fund and discharge the duties of the board. The annual assessment shall be calculated to provide funding that, at a minimum, is expected to be sufficient to cover the administrative costs of the board and fund the purchase of vaccines for program eligible children that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention on the date the board makes its assessment determination.

(3) For late or nonpayment of assessments by a carrier, the director shall impose interest at the rate provided by section 28-22-104(1), Idaho Code, and may impose such other penalties as provided in title 41, Idaho Code.

(4) Except as otherwise provided in this subsection, a carrier shall pay an assessment made by the board within sixty (60) days of the notice of assessment being sent to the carrier. For good cause, a carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment if the director determines that the payment of the assessment would place the carrier in a financially impaired condition, as provided in title 41, Idaho Code. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable to the fund for the amount deferred and shall be prohibited from insuring any new individuals in the state of Idaho until such time as it pays the assessments.

(5) The moneys raised by the assessment authorized in this section shall be used solely for the purposes expressly authorized by this chapter.

History.
I.C., § 41-6006, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 2, p. 331.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 121, in subsection (1), deleted "on or before March 1, 2010, and" following "shall report to the board" and deleted "thereafter" following "January 1" and added "and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter"; in subsection (2), added the first sentence, in the third sentence, inserted "any surplus funds remaining from a prior assessment," "and cost," and "expected to be" and added the last sentence; deleted former subsection (5), which read: "The initial assessments as determined by the board shall be paid into the fund on or before April 1, 2010"; and redesignated former subsection (6) as present subsection (5).

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6007. Idaho immunization dedicated vaccine fund. [Null and void, effective July 1, 2015.] — There is hereby created in the state treasury the Idaho immunization dedicated vaccine fund. Moneys in the fund shall be appropriated solely for purposes established by this chapter. All funds in excess to the cost required to perform the administrative functions required under this chapter shall be paid to the Idaho department of health and welfare for the sole purposes of purchasing vaccine for use in the Idaho immunization program. Any moneys in excess of the amount needed to fund the Idaho immunization program for a given period shall be retained by the Idaho department of health and welfare to be used to fund the program in subsequent periods, including a subsequent period after the date this chapter is no longer in effect. The fund and any assessments imposed or collected pursuant to the operation of the fund shall at all times be free from taxation of every kind.

History.

I.C., § 41-6007, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 3, p. 331.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 121, in the second sentence, substituted "required to perform the administrative functions required under this chapter" for "required to develop and amend a plan of operation as permitted in section 41-6004, Idaho Code" and added the third sentence.

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

41-6008. Rulemaking authority. [Null and void, effective July 1, 2015.] — Upon consultation with the board, the director shall have the authority to promulgate rules necessary to implement this chapter.

History.

I.C., § 41-6008, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.
Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2015."

CHAPTER 61

IDAHO HEALTH INSURANCE EXCHANGE ACT

SECTION.

41-6101. Short title. — This chapter shall be known and may be cited as the "Idaho Health Insurance Exchange Act."

History.
I.C., § 41-6101, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.
Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6102. Purpose and intent. — It is the public policy of the state of Idaho to actively resist federal actions that would limit or override state sovereignty under the 10th amendment of the United States constitution. Through this legislation, the state of Idaho asserts its sovereignty by refusing to surrender decision-making authority over health care issues, which are matters appropriately left to states and individual citizens. The purpose of this chapter is to establish a state-created, market-driven health insurance exchange that will facilitate the selection and purchase of individual and employer health benefit plans. The creation of a state-based health insurance exchange will provide an Idaho-specific solution that fits the unique needs of the state of Idaho. Participation in the exchange is voluntary in that no person or employer shall be required by this chapter to purchase a health benefit plan through the exchange. Creation of the exchange and its operation is deemed a public purpose intended to enhance Idaho residents' choice regarding options and access to health insurance.

History.
I.C., § 41-6102, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.
Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6103. Definitions. — For the purposes of this chapter:

(1) "Board" means those individuals who, acting as a board of directors of the exchange, govern and act for the exchange, pursuant to section 41-6104, Idaho Code.

(2) "Conflict of interest" means that by taking any action or making any decision or recommendation on a matter within the authority of the board, a member of the board, or a person within the member's household, or any entity with which the member, or a person within the member's household is associated, would receive a pecuniary benefit or detriment, unless the pecuniary benefit or detriment would apply to the same degree to a class consisting of all persons within the particular class in this state.

(3) "Director" means the director of the department of insurance of the state of Idaho.

(4) "Exchange" means the Idaho health insurance exchange established pursuant to this chapter.

(5) "Health carrier" has the same meaning as "carrier" as set forth in section 41-5203(5), Idaho Code.

(6) "Person" has the same meaning as set forth in section 41-104, Idaho Code.

(7) "Producer" has the same meaning as set forth in section 41-1003(8), Idaho Code.

History.
I.C., § 41-6103, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.
Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6104. Establishment of the exchange and the board. — (1) There is hereby created an independent body corporate and politic to be known as the "Idaho Health Insurance Exchange." Said exchange may exercise the authority and powers conferred by this chapter and such exercise shall be deemed and held to be the performance of an essential public function.

(2) The exchange created by this chapter is not a state agency, shall not be subject to the purchasing statutes and rules of the state of Idaho or subdivisions of the state including, but not limited to, chapters 28 and 57, title 67, Idaho Code, and shall operate subject to the supervision and control of its board.

(3) The board shall consist of nineteen (19) total members, with seventeen (17) voting members. Subject to the provisions of this section, members of the board shall collectively offer expertise, knowledge and experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health and health policy issues related to small employer and individual markets and the uninsured. A majority of the board shall not collectively represent health carriers and producers. The fourteen (14) voting members who are not members of the legislature shall be appointed to the board by, and serve at the pleasure of, the governor. The members appointed to the board by the governor shall be subject to confirmation by the senate, provided that, upon appointment, board members shall have full authority to exercise all the rights and duties, and participate in all decisions, required of the position. The seventeen (17) voting members of the board shall be appointed as follows:

(a) Three (3) members representing different health carriers appointed by the governor;

(b) Two (2) members representing producers appointed by the governor;

(c) Three (3) members representing individual consumer interests appointed by the governor;

(d) Four (4) members representing small employer business interests appointed by the governor with, at the time of appointment:

(i) One (1) member representing small employer business interests employing between one (1) and ten (10) employees;

(ii) One (1) member representing small employer business interests employing between eleven (11) and twenty-five (25) employees;

(iii) One (1) member representing small employer business interests employing twenty-six (26) or more employees; and

(iv) One (1) at-large member;

(e) Two (2) members representing health care providers appointed by the governor;

(f) One (1) member of the house of representatives appointed by the speaker of the house;

(g) One (1) member of the senate appointed by the president pro tempore; and

(h) One (1) member of the legislature representing the minority party in the legislature appointed by minority leadership.

The director or his designee and the director of the state department of

health and welfare or his designee shall each serve as ex officio nonvoting members of the board.

(4) The fourteen (14) board members appointed by the governor shall each serve a term of four (4) years or until a successor is appointed. A board member may be appointed by the governor to serve subsequent terms. A vacancy in a member's position on the board shall be filled in the same manner as the original appointment.

(5) Whenever a member of the board has a conflict of interest on a matter that is before the board, the member shall fully disclose it to the board, abstain from any vote on the matter and shall also comply with any additional requirements established pursuant to the plan of operation under section 41-6105, Idaho Code.

(6) Neither members of the board nor any other person working or performing services for the exchange shall be:

(a) Considered public officials, employees or agents of the state of Idaho by virtue of their service on the board or performance of services for the exchange; or

(b) Eligible for or entitled to benefits from the public employee retirement system of Idaho.

(7) Nothing in this chapter shall prevent a member of the board who is otherwise a current or former state employee from receiving his usual state compensation and benefits while serving on the board.

(8) All meetings of the board shall be held in accordance with the open meeting law as provided for in chapter 23, title 67, Idaho Code, shall be held in an open public forum, and every reasonable effort shall be made to make such meetings televised or streamed in video and audio format.

(9) The board shall contract for an annual audit of the exchange by an independent third party and shall accept requests for proposal to bid on such contract.

(10) The board shall develop, adopt and implement procurement policies and guidelines.

(11) Premium rates charged by a health carrier for a health benefit plan or stand-alone dental plan offered in the exchange shall be based upon Idaho rating areas established by the director consistent with 42 U.S.C. section 300gg, et seq.

History.

I.C., § 41-6104, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6105. Powers and authority of the exchange. — (1) Unless otherwise required by this chapter, in the discretion of the board, the exchange shall have the powers and authority to:

(a) Perform all duties that are necessary and appropriate to implement a health insurance exchange and the provisions of this chapter;

(b) Adopt bylaws for the regulation of its affairs and the conduct of its business, subject to the review and approval by the director. The director's consent shall be required for any amendment to the bylaws;

(c) Assess and collect fees from participating health carriers, exchange users and receive funds from any other source, that shall be used solely for the purposes of this chapter. The exchange shall not be subject to income tax imposed by the state of Idaho under chapter 30, title 63, Idaho Code;

(d) Appoint any advisory committees as deemed necessary by the board;

(e) Take any legal action to recover any amounts lawfully owed to the exchange or otherwise consistent with this chapter;

(f) Enter into contracts to effectuate and implement a health insurance exchange and shall accept requests for proposal to bid on such contracts; and

(g) Develop, adopt and implement a plan of operation and other governing documents to fulfill the requirements of this chapter.

(2) The exchange powers and authority shall be subject to the following limitations:

(a) The exchange shall not have the power to alter its own legal structure;

(b) The exchange shall be financially self-supporting and shall not request any financial support from the state and shall not have the power to tax or encumber state assets;

(c)(i) The exchange shall be a voluntary marketplace with the purpose of preserving individual choice and facilitating the informed selection and purchase of health benefit plans by eligible individuals, eligible employers and eligible employees. To that end the exchange portal shall be constructed to permit health insurance shoppers to anonymously input information to comparison shop, and only upon submission of an application require login names, passwords and identifying information.

(ii) Neither the exchange nor any agency of the state of Idaho shall require any person to use or participate in the exchange, nor have the authority to impose upon or collect from a person any penalty for failure or refusal to participate in the exchange or to purchase a health benefit plan or stand-alone dental plan.

(iii) The exchange shall provide as part of the application process for any person qualifying for premium assistance through the exchange a prominent warning advising purchasers to estimate income for the year carefully, that underestimating income can result in an overpayment of premium assistance and that an overpayment of premium assistance will likely result in owing the overpayment back to the internal revenue service.

(d) The exchange shall not prohibit a health carrier from participating in the exchange or prohibit a health benefit plan or stand-alone dental plan

from being sold in the exchange so long as the health carrier or health benefit plan or stand-alone dental plan meets all requirements of applicable law and any requirements of the exchange consistent with this chapter;

(e) The exchange shall not prohibit or preclude a health carrier from offering insurance or a stand-alone dental plan outside the exchange;

(f) The exchange shall not prohibit a producer from participating in the exchange, and any producer participating in the exchange shall be entitled to payment for his services through written fee agreements with the individuals or small employers utilizing the services of said producer or through commissions offered by health carriers participating in the exchange;

(g) Before the exchange begins taking applications or collecting information from exchange users, the board shall certify to the director and governor that personal information collected from and about any person who voluntarily uses the exchange including, but not limited to, health care records and income, is and will continue to be secure;

(h) The exchange shall not inquire about the use, ownership, possession or storage of any firearm or ammunition by anyone using the exchange;

(i) In the event the patient protection and affordable care act (PPACA), P.L. 111-148, or any section thereof or rule enacted thereto, is declared unconstitutional or otherwise invalid by any federal court, unless such ruling is stayed by the court, the exchange shall immediately cease to enforce those affected provisions of the PPACA or rules;

(j) The state of Idaho shall not be liable for any obligations of the exchange; and

(k) The board shall not be liable for any obligations of the exchange. No member of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members.

History.

I.C., § 41-6105, as added by 2013, ch. 170, § 1, p. 390; am. 2014, ch. 241, § 1, p. 608.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 241, in paragraph (2), added the paragraph designations, splitting the existing provisions of the subsection between paragraphs (i) and (ii), added the last sentence in paragraph (i), and added subsection (iii).

Federal References.

The patient protection and affordable care act (PPACA), P.L. 111-148, is codified throughout the United States Code, especially titles 26 and 42.

Compiler's Notes.

The abbreviations enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establish-

ment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6106. Report. — (1) The exchange shall submit a written report of its activities and the condition of the exchange to the director, the governor and the director of the legislative services office for distribution to all legislators on or before January 31, 2014, and annually on or before each January 31 thereafter. The exchange shall also report to the appropriate senate and house of representatives germane committees on any changes to its bylaws or policies and any changes or updates from the federal department of health and human services (HHS) regarding essential health benefits or operation or conditions of the exchange on or before January 31, 2014, and annually on or before each January 31 thereafter.

(2) For any changes by the board to the fee schedule charged to exchange users or participants, the exchange shall, at the next legislative session, report to the appropriate senate and house of representatives germane committees on or before January 31.

History.
I.C., § 41-6106, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Compiler's Notes.
The abbreviations enclosed in parentheses so appeared in the law as enacted.

Effective Dates.
Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6107. Relation to other laws. — The board and the exchange are entitled to rely upon work performed by the director and the director of the Idaho department of health and welfare in furtherance of the purpose of this chapter that are not otherwise inconsistent with their respective statutory duties and authority. Nothing in this chapter, and no action taken by the exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state pursuant to title 41, Idaho Code, and administer and enforce rules adopted in accordance therewith.

History.
I.C., § 41-6107, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6108. Idaho contractors in a health insurance exchange. — Pursuant to sections 41-6104 and 41-6105, Idaho Code, the board shall, to the fullest extent practicable, enter into contracts with businesses conducting business in Idaho and employing citizens of this state to staff and provide support for the exchange.

History.

I.C., § 41-6108, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.

41-6109. Severability. — The provisions of this act are hereby declared to be severable, and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

History.

I.C., § 41-6109, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Compiler's Notes.

The term "this act" refers to S.L. 2013, ch. 170, which is codified as §§ 41-6101 to 41-6109.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State." Approved March 28, 2013.